PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

27 October 2025-7 November 2025; 10, 13 and 20 February 2026; 7–8 and 10 April 2026; 28 July, 4 and 7 August 2026

Name:	KABIR, Jenefar Mosfie
Registration number:	79194
Case number:	CAS-200486 and CAS-200126

General Dental Council:	John Greany of Counsel Instructed by Clare Hastie of Kingsley Napley
Registrant:	Present Represented by Neil Sheldon of King's Counsel. Instructed by Emma Galland of Hill Dickinson

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased
Immediate order:	Immediate order of suspension

Committee members:	Fiona Abbott	(Lay) (Chair)
	Andrea Hammond	(DCP)
	Annika Hindocha	(Dentist)
Legal adviser:	Valerie Paterson	
Committee Secretary:	Paul Carson (Jenny Hazel 7–8 and 10 April 2026; Aysha Begum 4 August 2026)	

The Charge (as amended)

Jenefar Mosfie KABIR, a dentist, BDS University of Manchester 2001, was summoned to appear before the Professional Conduct Committee on 27 October 2025 for an inquiry into the following charge:

"Your fitness to practise as a dentist is impaired by reason of misconduct in that:

1. *On 28 September 2021, when treating Patient 1, you used a high-speed dental handpiece for bone removal during surgical extraction.*

2. *Between 12 November 2021 and February 2022, you failed to provide an adequate standard of care to patients 2,3,4,5,and 6 by failing to carry out sufficiently careful and/or adequate diagnostic assessments/checks prior to the patients being provided with treatment under sedation on the following dates;*

    a. *Patient 2 on 18 November 2021;*
    b. *Patient 3 on 15 November 2021;*
    c. *Patient 4 on 10 January 2022;*
    d. *Patient 5 on 1 December 2021;*
    e. *Patient 6 on 29 November 2021;*

3. *In January 2022 you administered an inappropriate concentration of midazolam to patients 2, 4 and 5. In the alternative, you failed to record or explain the reason for administering the concentration of the medication that you prescribed to them.*

4. *Between 12 November 2012 and February 2022 you failed to maintain an adequate standard of record keeping in respect of your appointments with Patients 2, 3, 4, 5, 6 and 7 on the following dates:*

    a. *Patient 2 on 18 November 2021 and 19 January 2022;*
    b. *Patient 3 on 15 November 2021;*
    c. *Patient 4 on 10 January 2022;*
    d. *Patient 5 on 1 December 2021 and 7 January 2022;*
    e. *Patient 6 on 29 November 2021;*
    f. *Patient 7 between November 2012 and March 2021.*

5. *You failed to obtain informed consent from patients 2, 3, 4, 5 , 6 and 7 and/or failed to obtain confirmation in writing from these patients that you had obtained their informed consent.*

6. *You prescribed antibiotics to patients 5, 6 and 7 without proper clinical justification and/or without recording the clinical justification and/or contrary to the prescription guidelines.*

7. *By virtue of the matters set out above at paras 1, 2, 3, 4, 5 and 6 you put patients at risk of harm.*

8. *Between 27 September 2021 and February 2022 you failed to maintain adequate standards of cross infection control in that you:*

a) *Failed to ensure that the practice's decontamination procedures met the essential quality requirements of HTM 01-05*
b) *Failed to ensure and/or check whether Colleague A had immunizations for and/or immunity to Hepatitis B before permitting Colleague A to be involved in clinical duties*
(including assisting chairside and carrying out decontamination procedures).
c) *Failed to provide appropriate training to Colleague A in respect of the decontamination process.*
d) *Failed to provide to staff members readily available liquid soap and/or antimicrobial handrub, in breach of HTM 01-05.*
e) *Failed to provide staff members with new clinical gloves that were fit for purpose*
f) *Instructed and/ or permitted staff to re-use clinical gloves*
g) *Reused clinical gloves yourself that should have been "single use"*
h) *Instructed and/or permitted staff to use disposable facemasks for inappropriately long periods of time in breach of HTM 01-05 (2.14/2.15).*
i) *Reusing and/or instructing staff to reuse other single use items at the surgery (e.g. disposable impression trays and sterilising pouches).*

9. *You failed to provide your employees with an appropriate induction and failed to ensure that each member of your team had an appropriate DBS check prior to starting their employment.*

10. *You failed to treat members of the dental team with an appropriate level of respect and courtesy including:*

(1) *In respect of Colleague A:*

a) *Asking Colleague A to undertake chores and work at the Registrant's mother's home when that was not part of her role or duties at the practice*
b) *Making belittling comments to Colleague A on one or more than one occasion*
c) *Snatching alginate from Colleague A.*

(2) *In respect of Colleague B being dismissive and/or rude and/or aggressive to her in January 2022 when Colleague B raised concerns about the running of the practice.*

(3) *Using foul language in front of dental colleagues on or around 20 October 2021.*

11. *You failed to ensure and/or check that all members of the dental team had appropriate training in relation to Basic Life Support."*

FINDINGS OF FACT – 20 February 2026 (amended 7 April 2026)

Ms Kabir,

The Committee commenced its factual inquiry on 27 October 2025 and adjourned part-heard upon the conclusion of the closing submissions of the parties on 7 November 2025. The Committee resumed in camera to deliberate on 10, 13 and 20 February 2026 and now announces its findings of fact.

As part of its factual inquiry, the Committee heard evidence from the following witnesses:

- Dentist A, employed by you at the Practice which is the subject of these proceedings (the 'Practice') between September 2021 and January 2022;
- Colleague A, an alleged trainee Dental Nurse employed by you at the Practice from around November/December 2021 until January 2022;
- Dental Nurse A, employed by you at the Practice from December 2021 to February 2022;
- Receptionist A, who has worked at the Practice for over ten years.

Colleague A was recalled to speak to further evidence that the General Dental Council (GDC) had obtained from her subsequent to her attendance as a witness on day three.

The Committee also heard evidence from you.

The witness statements of Dental Hygienist A and Dental Nurse B, relied upon by the GDC and by you respectively, were admitted as hearsay. These two individuals had worked for you at the Practice.

The Committee received opinion evidence from the following expert witnesses:

- Professor Nigel D Robb, PhD, BDS, FDS RCSEd, FDS(Rest Dent), FDSRCPS, FDTF, FHEA 110;
- Mr C Mulcahy BA BDentSci MSc;
- Mr C GP Holden. BDS, LDS, RCS Eng, DGDP (UK), FCGDent;
- Mr P J Smyth, a Dentist whose postgraduate qualifications were listed in an appendix to his report.

Professor Robb and Mr Mulcahy were instructed on behalf of the GDC. Mr Holden and Mr Smyth were instructed on your behalf. The Committee was greatly assisted by the reports and oral evidence of each of these experienced and distinguished experts.

In accordance with Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 the 'Rules'), the Committee acceded to applications made by the GDC to amend the charge contained in the notification of hearing. The Committee was satisfied that no injustice or prejudice would be caused to the parties in allowing the amendments. With the exception of an application made to amend charge 8 in closing, those applications were unopposed by you.

As to the application to amend charge 8 in closing, the Committee was satisfied that the proposed amendments (to change "using" and "use" to "reusing" and "reuse" in charge 8(i) and to change the date from 12 November 2021 to 27 September 2021 in the stem) would

more accurately reflect the evidence and the case which had been put to you. The Committee was therefore satisfied that these amendments would not result in prejudice or injustice.

Part of the hearing was held in private under Rule 53 of the Rules to protect your right to a private and family life.

The Committee had regard to the closing submissions made on behalf of the GDC by Mr Greany, and to those made on your behalf by Mr Sheldon KC.

The Committee accepted the advice of the Legal Adviser.

The burden is on the GDC to prove each allegation on the balance of probabilities.

I will now announce the Committee's findings in relation to each head of charge:

1.	AMENDED TO READ: *On 28 September 2021, when treating Patient 1, you used a high-speed dental handpiece for bone removal during surgical extraction.* **Not proved.** Patient 1 attended Dentist A on 28 September 2021. It was not in dispute that you took over the treatment from Dentist A during the appointment to complete an extraction. There was a conflict of evidence as to whether you had done so of your own motion or because Dentist A had asked you for help because she was struggling. Dentist A's account was that she nursed for you whilst you completed the extraction whilst your position was that your usual Dental Nurse stepped in. Dentist A's contemporaneous notes of the appointment record that the roots had been removed separately. In your evidence you concurred that you did remove the roots separately but that you had sectioned them using the high-speed dental handpiece to section the tooth but not remove bone. It was not in dispute between the experts that using a high-speed dental handpiece to remove bone would be inappropriate and would fall far below the standard reasonably expected of you. What was in dispute was whether you had used it for bone removal. You deny that you removed bone with a highspeed dental handpiece. Whilst the Committee regarded Dentist A to be a credible witness, the Committee could not be satisfied from her evidence taken as a whole that it is more likely than not that you removed bone during this procedure. When Dentist A made her complaint to the GDC, she made no reference to you removing the bone and instead stated that you had sectioned the tooth. Dentist A, both in her witness statement and oral evidence, gave varying accounts as to whether and to what extent she would have been able to see bone being removed and whether a buccal flap had been raised. The Committee accepted the expert opinion evidence that a scalpel would have been necessary to raise a buccal flap for bone to be removed. Both Dentist A and

	you stated that scalpels were kept in a surgical kit and that no surgical kit was present in the room at the time of the extraction. The contradictions and inconsistencies in Dentist A's recollection, and the necessity for a scalpel to have been available, meant that the Committee could not be satisfied from the contemporaneous notes alone, in the context of all the other evidence, that bone had in fact been removed. Accordingly, the Committee found this charge not proved.
2.	AMENDED TO READ: *Between 12 November 2021 and February 2022, you failed to provide an adequate standard of care to patients 2,3,4,5, and 6 by failing to carry out sufficiently careful and/or adequate diagnostic assessments/checks prior to the patients being provided with treatment under sedation on the following dates;*
	a. Patient 2 on 18 November 2021; **Admitted and found proved.**
	b. Patient 3 on 15 November 2021; **Admitted and found proved.**
	c. Patient 4 on 10 January 2022; **Admitted and found proved.**
	d. Patient 5 on 1 December 2021; **Admitted and found proved.**
	e. Patient 6 on 29 November 2021; **Admitted and found proved.**
	f. WITHDRAWN
3.	AMENDED TO READ: *In January 2022 you administered an inappropriate concentration of midazolam to patients 2, 4 and 5. In the alternative, you failed to record or explain the reason for administering the concentration of the medication that you prescribed to them.* **Not proved.** The Committee preferred the opinion of Mr Holden that the concentration of midazolam which you had administered to Patients 2, 4 and 5 was consistent with that which would be administered by a responsible body of practitioners. The Committee also accepted his opinion that there was no mandatory obligation on you to record or explain the reason for administering this concentration of medication, as it was in accordance with widely established practice.

	The Committee considered that Professor Robb had given evidence as to best practice. The Committee was satisfied that Mr Holden's opinion reflected what would reasonably occur and be acceptable in practice. Accordingly, the Committee found this charge not proved.
4.	*Between 12 November 2012 and February 2022 you failed to maintain an adequate standard of record keeping in respect of your appointments with Patients 2, 3, 4, 5, 6 and 7 on the following dates:*
	a. Patient 2 on 18 November 2021 and 19 January 2022; **Admitted and found proved.**
	b. Patient 3 on 15 November 2021; **Admitted and found proved.**
	c. Patient 4 on 10 January 2022; **Admitted and found proved.**
	d. Patient 5 on 1 December 2021 and 7 January 2022; **Admitted and found proved.**
	e. Patient 6 on 29 November 2021; **Admitted and found proved.**
	f. Patient 7 between November 2012 and March 2021. **Not proved.** This charge spans a period of over eight years in respect of which it appeared to be the GDC's case that you, among other treating clinicians for Patient 7, had failed to record a medical and social history. The records available to the Committee, which appear to be incomplete, do not contain a medical and social history. The uncontroversial opinion of Professor Robb was that you would have been under a duty to record a medical and social history. He stated in his report that: '*Within the documents provided in the bundle for this patient's treatment there were no medical history forms. There was reference to medical history checks at appointments on 19/02/2019 and 03/06/2014 'MH- no updates" this was not consistent or sufficient.*' However, in oral evidence, you stated that medical and social histories would have been taken on paper forms which would then have been scanned into the system separately and which have not been disclosed as part of these proceedings. Your evidence on this point was unchallenged. The Committee could not therefore be satisfied from the available evidence that the GDC has shown that it is more likely than not that you had failed to record a

	medical or social history. As Professor Robb notes in the quoted text above, there is some record in the notes of medical history checks. Whilst those entries are inadequate when read alone, they are consistent with your account that the medical history would have been taken on a separate paper form which was scanned into the patient's record and which has not been disclosed as part of these proceedings. Professor Robb's opinion was also that you failed to maintain an adequate standard of record keeping as there is a lack of recorded diagnoses for Patient 7. In his report, he stated: '*Diagnoses* *It is standard teaching that the diagnosis of the patient's condition should be recorded as an essential part of the examination. It is the foundation of what the practitioner can relay to the patient and the basis of the formulation of appropriate treatment plans. Diagnoses were not documented by the registrant in the notes.*' The Committee noted that the records indicated why the bridge was provided and was satisfied that this sufficiently recorded the patient's condition. The Committee could not be satisfied that the GDC has discharged its burden of proving that it is more likely than not that you failed to maintain an adequate standard of record keeping for Patient 7. The Committee accepted your evidence that medical and social histories were taken on paper forms and scanned into the system separately. It noted that this was unchallenged by the GDC. Accordingly, the Committee found this charge not proved.
5.	*You failed to obtain informed consent from patients 2, 3, 4, 5, 6 and 7 and/or failed to obtain confirmation in writing from these patients that you had obtained their informed consent.* **Proved in relation to Patient 7. Not proved in relation to Patients 2-6.** It was not in dispute that you had obtained written consent for Patients 2, 3, 4, 5 and 6 in relation to conscious sedation, in accordance with Standard 3.1.6 of *Standards for the Dental Team*, which states: '*You must obtain written consent where treatment involves conscious sedation or general anaesthetic.*' There was, however, a conflict of expert opinion as to whether the written consent for these patients also needed to encompass consent for the treatment which was to be provided under sedation. Professor Robb's opinion, as stated in the Joint Expert report, was that: '*The written consent for dental treatment under sedation must include consent for the dental treatment as well as the sedation. In the cases of patients 2,3,4,5 and 6, whilst the sedation instruction forms are signed, there is no description of the dental treatment. No signed treatment plans or consent forms for dental treatment are present. It follows that written consent for dental treatment under sedation has not been obtained as required by the Standards of the day.*' By contrast, Mr Holden's opinion, as set out in his report dated 16 September 2025, was that:

'65. Consent documentation for the consent process varies between dental sedationists. IACSD provides exemplars. Some general dental practitioners provide separate forms for written dental sedation consent and sedation instructions. Some practitioners combine these documents. In my experience both presentations are common practice in primary dental care.

66. I am asked to give opinion on patients 2,3,4,5 and 6. All these patients received a document titled "Sedation Guidelines". This document contains adequate information for the sedation consent process to be confirmed in writing. The consent process was further confirmed on the "[…] *Sedation Monitoring / Implant Form" on the day of the procedure. The documentation is not exemplary but contains the required elements of written confirmation of a valid consent process.*

67.The registrant says in her statement that written consent is taken "days prior to the procedure" and that "Written consent was always taken at the preop visit or before". She explains that "rx plan objectives revised and vgc" relates to regaining verbal consent on the day of the procedure.

68.On balance, this meets the standard of a responsible general dental practitioner.'

The Committee preferred Mr Holden's opinion. The Committee considered that Professor Robb was applying a higher standard than was required when formulating his nuanced opinion on this point. He appeared to be treating what might be best practice as a mandatory requirement. He was unable to identify when questioned any published guidance which expressly requires written consent to additionally be obtained in respect of the treatment itself. Neither could the Committee properly interpret any such mandatory requirement from the terms of the GDC's Standards or the Standards for Conscious Sedation in the Provision of Dental Care (2020) published by the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD).

In context, the Committee was satisfied that it is more likely than not that the written consent which you had obtained for these patients demonstrated obtaining informed consent for both the sedation itself and the inextricably linked corresponding treatment which was to be provided (and which was the purpose of the sedation).

Accordingly, the Committee found this charge not proved in relation to Patients 2, 3, 4, 5 and 6.

Patient 7's case is distinguishable, as it did not involve conscious sedation. The treatment in question was the fitting of a bridge on 22 July 2013. As recorded in the notes, you made an adjustment to the patient's occlusion or articulation in order to improve the fit of the bridge. It is this aspect of the treatment which Professor Robb is critical in terms of informed consent. In his report, he stated:

'It is normal practice that adjustments are required either when bridges are fitted or shortly thereafter. The movements of the lower jaw in function are

complicated and cannot be accurately replicated in the dental laboratory during construction of the bridgework.

Whilst ideally adjustments should be made to the prosthesis, it may be deemed more appropriate to adjust the opposing natural tooth or teeth especially if their shape or position is unusual. An example would be if the tooth had over erupted into the space of the missing tooth.

The patient should be informed of the procedure and the rationale in order to provide consent for that adjustment. There is no record of that discussion having occurred, which is contrary to the GDC standards:

o 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 at that appointment.

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

The failure to obtain informed consent for the adjustment falls far below the standard expected of a reasonable General Dental Practitioner. Providing treatment to an area of the mouth or teeth that the patient is not expecting could be distressing for the patient and may increase the risk of the patient moving during the treatment, putting them at risk of injury.'

The Committee had not heard evidence from Patient 7 neither had you given evidence on this matter, as, understandably, you cannot recall the detail of the patient's treatment from 2013. The GDC's case in support of this charge is based on the patient's records and the expert opinion of Professor Robb.

The records contain a written complaint from Patient 7 to you on 7 September 2021, complaining about, among other treatment provided by you, the bridge which the records show you fitted in 2013. This complaint asserted that what had been planned and consented to was a 2-unit bridge and a crown and not the 3-unit bridge which was eventually fitted. The Committee noted that the contemporaneous clinical notes which you made appear to be consistent with the patient's account in this regard. Patient 7 also alleged that, by reference to the clinical notes: '*It is noted that occlusion was problematic and significant material was removed from LL3 to accommodate (again without consent or plan).*'

The Committee determined from the clinical notes that you had adjusted Patient 7's occlusion or articulation in the region of LL3 in an attempt to improve the fit of the bridge. The Committee further determined that you did so without having discussed this adjustment to the treatment plan with Patient 7 first, as: (i) there is nothing in the clinical notes to indicate any such discussion taking place; and (ii) Patient 7 expressly complains that the adjustment was '*again without consent or plan*'.

The Committee accepted Professor Robb's opinion, by reference to 3.3.2 and 3.3.4 of the GDC's Standards, that you were under a duty to discuss the adjustment with Patient 7 first and to document this. The Committee was satisfied

	that your failure to have done so meant that you had failed to obtained Patient 7's informed consent to adjust his occlusion or articulation. Accordingly, the Committee found this charge proved in relation to Patient 7.
6.	*You prescribed antibiotics to patients 5, 6 and 7 without proper clinical justification and/or without recording the clinical justification and/or contrary to the prescription guidelines.* **Found proved in relation to Patient 6 and not proved in relation to Patients 5 and 7.** As a matter of fact, as recorded in the clinical notes, you prescribed the following antibiotics to Patients 5, 6 and 7: - Patient 5 on 10/01/2022 in respect of the placement of 6 Implants: Amoxycillin 2g, 1 hour pretreatment and Amoxycillin 200mg TDS for 7 days. - Patient 6 on 29/11/2021 in respect of an extraction: Metronidazole 400mg TDS for 7 days. - Patient 7 on 27/06/2018 at an examination: Metronidazole 400mg TDS 5 days. In respect of Patient 5, the Committee was satisfied that it is self-evident (even if not expressly recorded by you) that the clinical justification for the prescribing of the antibiotics was the implant treatment. Professor Robb's evidence was that 55% of Dentists would routinely prescribe antibiotics for such treatment. The Committee was not satisfied that this charge is made out in respect of the first limb of *'without proper clinical justification*'. As to the second limb, '*without recording the clinical justification*', the Committee determined that, although not expressly recorded by you, it would be obvious to any clinician reading the clinical notes in context and as a whole that the justification for the antibiotics was clearly the implant surgery. This was consistent with the expert opinion of Mr Smyth. Accordingly, the Committee was not satisfied that this charge is made out in respect of the second limb either. As to the third limb '*contrary to the prescription guidelines*', the Committee accepted the opinion of Mr Smyth that the prescribing of antibiotics for implant treatment is recommended in the Faculty of General Dental Practice (FGDP UK) Antimicrobial Prescribing for General Dental Practitioners guidelines Accordingly, the Committee found Charge 6 not proved in its entirety in respect of Patient 5. As to Patient 6, the records show that the patient was an irregular attender and was suffering from a gum infection following an extraction. The Committee accepted your evidence that you did not consider the patient was likely to return and that you prescribed the antibiotics as you wanted to give him a 'good experience' in relation to his dental treatment and wanted to facilitate his re-engagement in his dental treatment. The Committee was not, however, satisfied

that this amounted to a clinical justification for the prescribing of antibiotics when, on the expert evidence, there was no other clinical justification.

In this regard, the Committee accepted the opinion of Professor Robb, as set out in his report:

> *'It is particularly difficult to see the justification for the prescription of metronidazole after the simple extraction of a periodontally involved upper molar in patient 6. There is nothing in the notes to indicate that there was any significant infection present before the tooth was extracted. There is also nothing to indicate that the extraction was difficult. It is noted that the tooth was periodontally involved, but the absence of adequate notes of the examination does not allow the severity of the periodontal involvement to be assessed. It would not be normal practice to prescribe antibiotics after a simple extraction. The instructions that are noted as being given to the patient include 'advised re contraceptive pill'. The sedation record indicates that the patient was taking no medication, and the clinical record records 'MH checked – NID' in two separate entries both dated 29/11/2021. Also given the patient was aged 59 years at the time of treatment, it would be highly unusual for her to be taking a contraceptive pill. It is my opinion that this is an example of a pre-created note being dropped into the record without editing for the context. ...Metronidazole has no effect on the efficacy of any contraceptive pill. In regard patient 6, the registrant's conduct falls below the standard expected in that the prescription of metronidazole was not justified in the clinical notes, there is no obvious reason from the notes to justify the prescription and the advice given to the patient was factually incorrect*.'

In the Committee's judgment, it was purely speculative of you to conclude that the patient was an irregular attender and would be more likely to re-engage in his dental treatment if antibiotics were prescribed. There was no rational or objective basis to that clinical assessment and the prescribing was, in any event, not clinically justified (neither was your purported justification recorded in the notes). It is inconsistent with prescription guidelines to prescribe antibiotics without clinical justification.

Accordingly, the Committee found charge 6 proved in its entirety in respect of Patient 6.

As to Patient 7, Professor Robb appeared to resile from his original criticism upon further review of the clinical records. Reading those records as a whole, the Committee was satisfied that there was sufficient clinical justification in support of the prescribing of the antibiotics. There was an earlier prescription on 19 June 2018 following the patient's emergency attendance with an abscess. When the patient re-attended on 27 June 2018 (the date of the prescription which is the subject of this charge) the notes record that the patient was still in pain, that root canal treatment was indicated and that the patient was about to go on holiday. Prescribing a 5-day course of antibiotics at this appointment as the patient was about to go on holiday before root canal treatment could be provided was clinically justified and was consistent with the prescription guidelines, which permit the prescribing of antibiotics pending treatment or referral.

	When the patient returned from their holiday and re-attended on 12 July 2018 for the root canal treatment, the notes record that the patient stated that the antibiotics had helped with the pain. The Committee was therefore satisfied that you had prescribed the antibiotics with clinical justification, that this was apparent from the notes read as a whole and that the prescribing was consistent with prescription guidelines. Accordingly, the Committee found this charge proved in relation to Patient 6 and not proved in relation to Patients 5 and 7.
7.	*By virtue of the matters set out above at paras 1, 2, 3, 4, 5 and 6 you put patients at risk of harm.* **Found proved.** In light of the Committee's findings above, the remaining charges to which charge 7 applies are charges 2, 4(a)-(e), 5 and 6. The Committee determined that its findings under these charges put patients at risk of harm. The Committee accepted the joint opinion of Professor Robb and Mr Holden, who both supported this charge in relation to charges 2 and 4. You acknowledged the joint position of the experts on this issue. In relation to charge 5, the Committee accepted the evidence of Professor Robb in relation to Patient 7. He stated that '*providing treatment to an area of the mouth or teeth that the patient is not expecting could be distressing for the patient and may increase the risk of the patient moving during the treatment, putting them at risk of injury*'. In relation to charge 6, the Committee accepted the opinion of Professor Robb, who stated that the over and inappropriate use of antibiotics has been blamed for the emergence and spread of resistant strains of bacteria. The Committee was satisfied that, to that extent, you put Patient 6 at risk of harm. Accordingly, the Committee found this charge proved.
8.	AMENDED TO READ: *Between 27 September 2021 and February 2022 you failed to maintain adequate standards of cross infection control in that you:*
	a) Failed to ensure that the practice's decontamination procedures met the essential quality requirements of HTM 01-05 **Found proved.** There was potentially some overlap in the GDC's case in respect of sub-head of charge 8(a) with the matters alleged under sub-heads 8(b)-(j) below. The Committee therefore first considered those sub-heads before returning to determine charge 8(a). Having done so, and having found charges 8(b), (c), (e), (f), (g), (h) and (i) proved, the Committee determined that these matters, individually and/or cumulatively, constituted a failure to ensure that the Practice's decontamination procedures met the essential quality requirements of HTM 01-05.

	Accordingly, the Committee found this charge proved.
	b) Failed to ensure and/or check whether Colleague A had immunizations for and/or immunity to Hepatitis B before permitting Colleague A to be involved in clinical duties (including assisting chairside and carrying out decontamination procedures). **Found proved.** To decide this and a number of the subsequent charges, it was necessary for the Committee first to determine the status of Colleague A within the Practice. It was not in dispute that she worked for you from around November/December 2021 until January 2022, albeit without any written contract of employment. Her mother was already employed by you at the Practice as a receptionist and had introduced you to her. Colleague A's evidence was that you had agreed to employ her as a trainee Dental Nurse and that the work which she undertook for you included, among other duties, providing chairside assistance and carrying out decontamination procedures. Your evidence was that you had only employed Colleague A to act as a carer for a relative and to undertake ad hoc social media work to promote the Practice. You deny that you had ever agreed to take her on as a trainee Dental Nurse. In particular, you deny that she had undertaken any clinical duties at the Practice. It was not in dispute that Colleague A's responsibilities included acting as a carer for your relative (Colleague A's evidence was that her understanding was that those duties would only be occasional and temporary) and undertaking social media work for the Practice. What was in dispute was whether her duties also included the clinical duties of a trainee Dental Nurse. Whether Colleague A undertook such clinical duties is the crux of the matter which the Committee is to decide, as this goes to whether or not you were under a duty to have ensured or checked that she was suitably immunised for such work in accordance with GDC Standards. The Committee found Colleague A's evidence to be straightforward, reliable, consistent and corroborated by other documentary evidence which she was able to produce. There was nothing to suggest to the Committee that she was lying, exaggerating or was otherwise mistaken in her recollection. There was nothing to suggest that she held any grudge or animosity towards you, or that she would otherwise have any reason to mislead the Committee when giving evidence on oath. It was only when being cross-examined on your behalf by Mr Sheldon KC that it was put to Colleague A that she had never worked at the Practice as a trainee Dental Nurse and so had never undertaken any clinical duties. In response, she referred to the existence of, among other things, videos she had taken of herself wearing scrubs in surgery and photos of staff rotas which had her name down as the Dental Nurse supporting other clinicians at the Practice, including yourself. She also stated that she would be recorded as the Dental Nurse assisting in the clinical records for the patients who were treated on those occasions.

The videos and photos were subsequently obtained by the GDC and admitted into evidence as part of these proceedings with Colleague A being recalled to exhibit those documents under oath. The clinical records to which she referred were not obtained, as those records (if any) were no longer in your control and neither you nor the GDC had access to them.

The timestamped videos which were exhibited were all taken by Colleague A and consisted of two videos on 17 and 20 December 2021 showing her wearing scrubs in a surgery at the Practice and three videos of her making moulds at the Practice on 21 December 2021. In one of the videos a bloodied extracted tooth is visible.

The photos of the rotas at the Practice showed that Colleague A's name was on the rota on 5, 7, 10, 13 and 14 January 2022. Colleague A explained in her oral evidence that the rota showed that, on 7 January 2022, she was scheduled to nurse for you; and that, on 13 January 2022, she was scheduled to assist a Clinical Dental Technician at the Practice; and that, on 14 January 2022, she was again scheduled to nurse for you and that another nurse was scheduled to assist Colleague B.

The Committee had no reason to doubt the authenticity of the videos and photos. The videos are consistent with Colleague A in fact undertaking the clinical duties of a trainee Dental Nurse. The evidence before the Committee was that the surgery rooms were kept locked when not in use. One of the videos appeared to have been taken within the surgery rooms which was consistent with Colleague A's evidence that she was working as a trainee Dental Nurse at the time.

The Committee also found Colleague A's answers to questions about the duties she undertook to be persuasive. She was able to naturally describe in detail the chairside and decontamination duties which she said she had undertaken at the Practice. The Committee determined that this level of detail was consistent with her actually undertaking those duties as opposed to merely observing others in the Practice doing them. There was no evidence that she had any prior or subsequent experience of working as a trainee Dental Nurse. After she left your employment she pursued other career options.

The Committee rejected your evidence that the photos of the rotas could not be accurate as you rarely undertook clinical work on Fridays. In respect of the rota entry for Friday 7 January 2022, in which Colleague A was on the rota, there happens to be a clinical record in the bundle before the Committee of a clinical note you had made in respect of implant treatment you had provided to Patient 5 on that Friday. This is consistent with the rota entry recording you as undertaking clinical work that day with Colleague A to provide dental nursing support.

The Committee also had regard to the screenshots of WhatsApp messages between you and Colleague A on which you sought to rely. The Committee was satisfied that whilst they show discussion about caring responsibilities for your relative they also contain embedded references which are consistent with Colleague A's account that she was being employed by you as a trainee Dental Nurse and that her duties were not limited to caring responsibilities or ad hoc

	social media work. Accordingly, the Committee accepted Colleague A's evidence and rejected your account that what she was saying was part of a conspiracy against you. Having established the facts in relation to Colleague A's role at the Practice, the Committee next considered whether you had failed to ensure and/or check whether she had immunisations for and/or immunity to Hepatitis B before permitting her to be involved in clinical duties (including assisting chairside and carrying out decontamination procedures). The Committee accepted Mr Mulcahy's opinion that you were under a duty to ensure that Colleague A was immunised: '*HTM 01-05 requires employers to ensure that staff involved in decontamination procedures demonstrate immunity to Hepatitis B*'. The Committee accepted Colleague A's evidence that she "*was never required to get any vaccines or booster shots*". There was no evidence that you had undertaken any risk assessment as to Colleague A's immunity to Hepatitis B. The Committee was satisfied that you failed to ensure and/or check whether Colleague A had immunisations and/or immunity to Hepatitis B before permitting Colleague A to be involved in clinical duties. Accordingly, the Committee found this charge proved.
	c) Failed to provide appropriate training to Colleague A in respect of the decontamination process. **Found proved.** The Committee acceptedMr Mulcahy's opinion that you were under a duty to provide appropriate training: '*If it was the case that* [Colleague A] *did not receive appropriate training for her role in the decontamination process, then in my opinion JK's standard of professionalism would have been far below that expected. This is because it would demonstrate either an ignorance of longstanding requirements or a disregard for said requirements. It, also, had the potential to put* [Colleague A] *and patients at risk of serious infection.*' The Committee accepted Colleague A's evidence that you had provided her with no appropriate training, which was not disputed by you as you deny that you had permitted her to be involved in decontamination procedures. Accordingly, the Committee found this charge proved.
	d) Failed to provide to staff members readily available liquid soap and/or antimicrobial handrub, in breach of HTM 01-05. **Not proved.** The Committee could not be satisfied from the evidence that it is more likely than not that you had failed to provide staff members with readily available liquid soap and/or antimicrobial handrub. Photos which you had provided of the Practice

	showed soap and soap dispensers in the background. The evidence of Receptionist A was that soap was readily available to staff in the Practice. In addition, the evidence of Colleague A and Dental Nurse A was that Fairy Liquid soap was available throughout the Practice, albeit in cupboards rather than out on the counter (the expert opinion evidence was that, although unconventional, there is no reason why Fairy Liquid soap would not meet the requirements of HTM 01-05). In her witness statement, Dental Nurse A had stated that there was no hand sanitiser at the Practice but not that there was no liquid soap available. In her witness statement, Colleague B had stated that there was no hand sanitiser at the Practice but not that there was no liquid soap available. The Committee took account of the experts' evidence regarding the inherent unlikelihood that clinicians at the Practice would be willing to work without readily available liquid soap and/or antimicrobial handrub. Moreover, Dentist A, who made a detailed list of alleged clinical governance failings in the Practice, made no mention of the absence of readily available liquid soap and/or antimicrobial handrub. If it were really the case that something as basic as this were not readily available, the Committee determined that it is more likely than not that she would at least have made some reference to it in her list of concerns and/or evidence. You denied the charge and gave evidence that liquid soap was readily available. Accordingly, given the photographic evidence showing soap dispensers and the inconsistent accounts of the availability of liquid soap, the Committee could not be satisfied that the GDC had discharged its burden of proof and therefore found this charge not proved.
	e) Failed to provide staff members with new clinical gloves that were fit for purpose **Found proved.** The evidence in support of this charge is based on the accounts of Dentist A, Colleague B and Dental Nurse A, who stated that gloves were not provided. Dentist A stated in evidence that: '*Upon starting at the Practice, I noticed instantly that the trainee dental nurse I had been put with was not complying with basic cross infection control standards. She was not wearing clinical gloves, rather, the kind of gloves caterers use for food preparation because this is what Jenefar Kabir had told her to wear. I knew this because I asked why she was wearing those gloves and she told me that the nurses had been told to wear them and save the nitrile clinical gloves for the clinicians*'. Dentist A described the gloves which had been provided to the trainee dental nurse as being oversized and unsuitable for clinical work. Colleague B stated in her witness statement that: "*There was an overall lack of PPE, such as nurses being given cheap high street vinyl gloves rather than*

	proper surgery gloves". Dental Nurse A stated that non-standard gloves were provided for use in the decontamination unit, describing these as being like those used for food industry, which were thinner and larger than clinical gloves. She stated that clinical gloves were, however, provided for use in the surgery room. The Committee accepted the accounts of these three dental professionals. The Committee rejected your suggestion that their evidence was given maliciously as part of a conspiracy against you. The Committee determined that you provided staff members with non-standard gloves to use for clinical and decontamination procedures which were not fit for purpose. This was most likely done as a cost saving measure. Rather than providing clinical gloves, you provided thinner lower grade gloves which were for everyday use, such as food preparation, and which would not fit properly as they would be too large. The Committee accepted the expert opinion that this would amount to a failure to maintain an adequate standard of infection control. Accordingly, the Committee found this charge proved.
	f) Instructed and/ or permitted staff to re-use clinical gloves **Found proved.** The Committee accepted the evidence of Dentist A and Colleague A that you instructed or permitted staff to re-use clinical gloves. Dentist A stated: '*I was asked to see one of JK's patients with a view to them being booked in with me for a crown. I put on a pair of gloves to examine the patient, picked up a mirror and probe to look in the patients mouth but did not directly touch the patient with the gloves. I took the gloves off and put them in the sink. After the patient left the surgery, JK took the gloves that I had worn out of the sink and said 'PPE is expensive, if you don't touch the patient directly then don't dispose of the gloves.' Other members of staff confirmed to me this was usual for JK. I found this very concerning.'* Colleague A stated: '*the gloves had to be worn for multiple patients. I got away with this because I kept putting clean gloves in my pocket and changing them over, but she did not see me changing them*'. And that '*JK was highly concerned about saving money. For example, she would use the same gloves on multiple patients, putting these in her pocket or in the sink in between patients, and touching door handles. She did not think there was anything wrong with this*'. Dental Nurse A also gave evidence that she had been asked by you to re-use gloves between patients if she had not touched the patient. She stated that you told her that if the gloves did not have saliva or blood on them they could be reused.

	The Committee accepted the opinion ofMr Mulcahy , as quoted under charge 8(g) below, that this would amount to a failure to maintain an adequate standard of infection control. Accordingly, the Committee found this charge proved.
	g) Reused clinical gloves yourself that should have been "single use" **Found proved.** The Committee accepted the accounts of Dentist A and of Colleague B that they had observed you re-using clinical gloves when treating patients. The Committee accepted the opinion of Mr Mulcahy that: '*If the Committee was to accept that JK re-used gloves on patients as opposed to discarding them after each patient, then in my opinion this would represent a standard far below that expected. This is because it would be a breach of longstanding guidance (HTM 01-05)2. Similarly, if the Committee was to accept that JK instructed staff members to re-use gloves, this would also in my opinion represent a standard far below that expected for the same reason'.* Accordingly, the Committee found this charge proved.
	h) Instructed and/or permitted staff to use disposable facemasks for inappropriately long periods of time in breach of HTM 01-05 (2.14/2.15). **Found proved.** The Committee accepted the evidence of Dentist A that you requested staff put initials on their masks so that they could reuse them. She provided the Committee with a screenshot of a WhatsApp message which you had sent to all staff on 15 December 2021 stating: '*can everyone please clearly mark their masks with initials so that it* [sic] *taken off they can be identified. Theres wasted masks all over the place'*. Your evidence was that you sent this message in respect of masks used in non-surgical areas of the Practice so that staff would not accidently put on a mask worn by another colleague. The Committee rejected your account. The wording of your message ('wasted masks all over the place') is not consistent with an intention simply to ensure that colleagues don't inadvertently put on a mask which had been worn by someone else. The wording of your message, and the accompanying photo you circulated of discarded masks, was consistent with an intention that staff put their initials on their masks so that they could re-wear them rather than discard them. The Committee also accepted the evidence of Colleague A that staff were expected to re-wear their masks until the mask started to disintegrate. She stated: '*JK would make us keep the same mask for much longer than was recommended and described them as a waste of money. I believe the longest time a single mask is meant to be used in a clinical setting is 3 hours, however she would make us collect a mask on a Monday, write our names on it and wear it until at least Wednesday*'.

	The Committee also accepted the evidence of Dental Nurse A that: '*JK instructed me to use one mask for the whole day and to write my name on it, stating 'PPE is expensive*'. The Committee also accepted the statement of Colleague B that: '*JK wanted us to reuse single use masks which one of the nurses told me on my first day. I found this an obvious contravention of cross infection principles, and especially worrying considering it had not been long since Covid'*. The Committee accepted the opinion of Mr Mulcahy that: '*If the Committee was* [sic] *to accept that JK intended for staff to wear soiled facemasks for extended periods, then in my opinion this would represent a standard far below that expected. This is because it would be in breach of HTM 01-05.*' Accordingly, the Committee found this charge proved.
	AMENDED TO READ: *i) Reusing and/or instructing staff to reuse other single use items at the surgery (e.g. disposable impression trays and sterilising pouches).* **Found proved.** The Committee accepted the evidence of Dentist A, Dental Nurse A, Colleague A and Colleague B. Dentist A stated that single use instruments were frequently re-used within the Practice, such as stainless stell burrs which she noticed had rust on them from re-use. Dental Nurse A stated that she was aware that staff were washing single use impression trays, which could only have been for the purpose of re-using them. Colleague B stated that she was told by a dental nurse not to re-seal single use sterilising pouches so that these could be re-used. Accordingly, the Committee determined that it is more likely than not that you reused and/or instructed staff to reuse single use items at the surgery. The Committee accepted the uncontroversial expert opinion that the re-use of single use items would amount to a failure to maintain adequate standards of cross-infection control. Accordingly, the Committee found this charge proved.
9.	*You failed to provide your employees with an appropriate induction and failed to ensure that each member of your team had an appropriate DBS check prior to starting their employment.* **Found proved.** The Committee accepted the evidence of Dentist A, Dental Nurse A and Colleague A that no appropriate induction had been given to them upon joining the Practice. For example, they were not shown where the emergency kit at the Practice was located as part of an induction and had to ask where it was.

	The Committee accepted the evidence of Colleague A that, although she had a DBS certificate from a previous role, she was never asked to provide this. The Committee accepted the evidence of Dental Nurse A that she was never asked for a DBS certificate. The Committee was satisfied from 1.9.1 of the GDC's Standards that: '*You must find out about, and follow, laws and regulations affecting your work. This includes, but is not limited to, those relating to: …• employment…*'. And from 6.6.1 of the GDC's Standards that: '*You should make sure that all team members, including those not registered with the GDC, have: • a proper induction when they first join the team…*' Accordingly, the Committee found this charge proved.
10.	*You failed to treat members of the dental team with an appropriate level of respect and courtesy including:*
	(1) In respect of Colleague A:
	AMENDED TO READ: *a) Asking Colleague A to undertake chores and work at the Registrant's mother's home when that was not part of her role or duties at the practice* **Not proved.** The Committee was not satisfied from the evidence that this would have amounted to a failure to treat Colleague A with courtesy and respect. It had always been the understanding between the two of you that her duties would include acting as a carer. What was in dispute was whether this would be a temporary or permanent arrangement and how much of her working time was to be devoted to the caring responsibilities. Those caring responsibilities were consistent with Colleague A's previous experience as a carer and were something she had said she would be willing to undertake. Accordingly, the Committee found this charge not proved.
	b) Making belittling comments to Colleague A on one or more than one occasion **Found proved.** The Committee accepted Colleague A's evidence that you: '*would frequently make belittling comments towards me about my lack of dental knowledge despite her not teaching or training me'*. The Committee viewed that the words used in relation to 10(c) below were belittling and that this amounted to a failure to treat Colleague A with an appropriate level of courtesy and respect. Accordingly, the Committee found this charge proved.
	c) Snatching alginate from Colleague A. **Found proved.**

	The Committee accepted the evidence of Colleague A that '*Jenefar Kabir came over, snatched it from my hands in front of the patient and said something along the lines of 'this is ruined, we're going to have to do another one, do you know how expensive this is?' This would make me feel embarrassed, insecure and just disrespected generally.*' The Committee was satisfied that this amounted to a failure to treat Colleague A with an appropriate level of courtesy and respect. Accordingly, the Committee found this charge proved.
	(2) In respect of Colleague B being dismissive and/or rude and/or aggressive to her in January 2022 when Colleague B raised concerns about the running of the practice. **Found proved.** Whilst the witness statement of Colleague B was before the Committee as hearsay, it was corroborated by the evidence of Dental Nurse A who described you as speaking loudly and rudely to Colleague B and that you were '*quite aggressive*' towards her. The Committee was satisfied that this amounted to a failure to treat Colleague B with an appropriate level of courtesy and respect. Accordingly, the Committee found this charge proved.
	(3) Using foul language in front of dental colleagues on or around 20 October 2021. **Found proved.** The Committee accepted the evidence of Dentist A that you had '*started ranting about all patients using foul language*' at a staff meeting in the Practice on or around 20 October 2021, including the use of 'the F-word'. Whilst you deny this, the Committee found Dentist A's evidence to be credible and consistent. The Committee was satisfied that this amounted to a failure to treat colleagues with an appropriate level of courtesy and respect. Accordingly, the Committee found this charge proved.
11.	*You failed to ensure and/or check that all members of the dental team had appropriate training in relation to Basic Life Support.* **Found proved.** The Committee accepted the evidence of Dentist A, that she had raised concerns with you '*that there had been no BLS (basic life support) training and none was planned for the team*'. The Committee also accepted the evidence of Colleague A that she had never received any medical emergency training. The Committee also accepted the expert opinion evidence that you were under a duty to ensure and/or check that all members of the dental team had appropriate training in relation to Basic Life Support. Accordingly, the Committee found this charge proved.

We move to Stage Two.

STAGE TWO - 7 August 2026

1 The Committee received two Defence bundles at this stage of proceedings. The first bundle, comprising approximately 460 pages, included:

- Your stage 2 statement dated 2 April 2026 in which you set out your reflections on the concerns raised by the GDC on certain aspects of your clinical practice and the steps you have taken to remediate the concerns identified in this case under the following headings: conscious sedation; record keeping & consent; antibiotic prescribing; infection control; staff checks relating to DBS, hepatitis B and BLS training, and concerns relating to behaviour.
- Copies of Care Quality Commission (CQC) inspection reports dated 28 February 2022 and 17 June 2022
- Copies of Certificates of Continuing Professional Development (CPD) completed, including courses relating to consent, conscious sedation technique, complaints handling, radiography and Infection Control
- Clinical audit of Antimicrobial Therapy
- Copies of sedation reports and logs, as well as anonymised examples of completed sedation forms
- Copies of proforma consent forms and sedation forms
- Testimonials from professional colleagues and members of staff working at the Practice, all of whom had knowledge of the allegations, together with a report dated 18 March 2026 from your Workplace Supervisor, who also had knowledge of the allegations;
- Patient reviews
- Employment related documentation from February 2022 to October 2022

2 The second bundle, comprising some 19 pages, contained further certificates of CPD. You also provided oral evidence at this stage of the proceedings.

Submissions by both parties

3 In accordance with Rule 20, the Committee heard submissions from Mr Greany on behalf of the GDC and those made by Mr Sheldon on your behalf. Both parties submitted that the GDC's "Guidance for the Practice Committees, including Indicative Sanctions Guidance" (October 2016, updated December 2020) (the GDC's Guidance 2020) is the appropriate version to use, given that this case began in 2025 (prior to the new GDC's guidance coming into effect in January 2026). The Committee has accepted the advice of the Legal Adviser.

4 Mr Greany submitted that the facts found proved are serious and amount to a falling short of what would be judged to be proper in the circumstances. He submitted that you have breached three fundamental standards of the GDC's "Standards For the Dental Team" - namely the requirement to treat patients in a hygienic and safe environment (1.5); the requirement to put patients' interests before your own or those of any colleague, business

or organisation (1.7) and the requirement to find out about laws and regulations that affect your work and follow them (1.9). Mr Greany submitted that the Committee's findings in relations to allegations 2, 4 and 8 fall at the serious end of the spectrum, both individually and cumulatively. He submitted that the matters in relation to allegation 8 (a failure to maintain adequate standards of cross infection control, including a failure to check whether Colleague A had immunisations for and/or immunity to Hepatitis B before permitting Colleague A to be involved in clinical duties) were not a one off incident but was a deliberate decision on your part.

5 Mr Greany submitted that a finding of current impairment is necessary for the protection of the public and is also required on the grounds of the public interest. This was in light of the serious risk of harm, the risk of actual clinical harm, as well as the reputational harm caused to the profession. He invited the Committee to have regard to the specific points raised by the experts in their report on the matters of health and safety and its impact on colleagues.

6 Mr Greany acknowledged that you have engaged in CPD, having completed a number of online courses. However, he submitted that 'there has been no evidence of genuine remorse expressed, no meaningful insight and no explicit acknowledgement about any of the concerning aspects in relation to Colleague A'. He reminded the Committee that you denied these allegations at the outset, as was your right, but that there was no acknowledgement of fault at this stage of the proceedings following on from the Committee's findings. Furthermore, in your evidence at stage one of these proceedings you did not appear to accept that there was a power imbalance between you and that of Colleague A, who was a "junior" colleague. Mr Greany submitted that your fitness to practise is currently impaired by reason of your misconduct.

7 Mr Greany submitted that given the serious nature of misconduct, the serious departure from 3 of the GDC's standards as well as your lack of insight, the appropriate sanction is that of erasure.

8 Mr Sheldon confirmed that you have no fitness to practise history and no adverse findings against you by the GDC. You have never appeared before a PCC in your career of some 24 years as a registered dentist. He submitted that there is considerable evidence before the Committee to demonstrate that you are a sound and highly performing dentist who is highly regarded and who has carried out more complex dentistry without any reported concerns. Mr Sheldon submitted that you have reflected on the gravity of the findings against you and you have taken steps to address all of the concerns identified in this case. He invited the Committee to play close regard to the documents contained in the Stage 2 bundle which provide evidence of the remediation you have undertaken as well as your insight into the matters in this case. The events in question, which cover the period from late 2021 until early 2022, should be seen in the context of a dentist who has been practising for some 25 years without any concerns both before and after the events in question. They could be described as historic concerns arising in a short window of an otherwise highly performing dentist.

9 Mr Sheldon made submissions in relation to the six issues in this case - consent, antibiotic prescriptions, sedation in clinical practice, infection control, practice administration and personal behaviour towards other members of staff. In short, Mr Sheldon submitted that there is insufficient basis to conclude that the findings against you amount to misconduct, or if they did, that they would be repeated. Mr Sheldon submitted that they could be described as single isolated incidents where you have taken steps to address the

concerns. Further, there have been no patient complaints since the events in question and no evidence to suggest any current deficiencies in relation to the matters found proved.

10 Mr Sheldon submitted that you have reflected on the shortcomings identified in this case and you have taken appropriate steps to embed changes into your practice, as confirmed in the CQC reports, the clinical audits carried out by your Workplace Supervisor, the changes to your practice you have introduced as well as the testimonials provided by dental professionals. In short, Mr Sheldon submitted that the issues of concern identified either do not amount to misconduct, or if they do, they have been fully remediated. He submitted that a finding of current impairment on the grounds of the protection of public is not necessary given your insight, your reflections, the remediation you have undertaken and the absence of any repetition of the events in question, which took place towards the end of 2021/early 2022.

11 Mr Sheldon further submitted that this was not a case where it is necessary to reach a finding of current impairment on the grounds of public interest. In support of that contention Mr Sheldon referred to evidence of your remediation of the matters identified in this case, where you have engaged throughout the process. Further, Mr Sheldon submitted that you have been subject to these proceedings for over four years, which has impacted on you professionally and personally. Given the vast amount of work you have undertaken, there is a strong public interest in maintaining the services of an otherwise experienced and competent dentist.

12 During the course of his submissions, Mr Sheldon set out the challenging circumstances that you were facing in relation to your private life at the time of the events in question. While acknowledging that this was not an excuse for why you behaved in that way, he invited the Committee to take this into account.

13 Mr Sheldon did not address the Committee on the matter of sanction. However, he submitted that a finding of current impairment was likely to have a negative effect on you obtaining a Certificate of Good Standing from the GDC, were you minded to seek employment as a dentist outside the UK.

14 The Committee has considered the submissions carefully. It has accepted the advice of the Legal Adviser. Throughout its deliberations, the Committee has had regard to the GDC's Guidance (October 2016, updated December 2020).

Misconduct

15 The Committee first considered whether the facts found proved amount to misconduct. The Committee has found proved the following:

- Between 12 November 2021 and February 2022, you failed to provide an adequate standard of care to patients 2,3,4,5, and 6 by failing to carry out sufficiently careful and/or adequate diagnostic assessments/checks prior to the patients being provided with treatment under sedation. You therefore put these patients at risk of harm (charges 2 and 7).

- Between November 2021 and February 2022, you failed to maintain an adequate standard of record keeping in respect of your appointments with patients 2, 3, 4, 5 and 6. You therefore put these patients at risk of harm (charges 4 and 7).

- You failed to obtain informed consent from patient 7 in relation to changing the treatment plan for the bridge in July 2013. You therefore put patient 7 at risk of harm (charges 5 and 7).

- You prescribed antibiotics to patient 6 On 29 November 2021 without proper clinical justification and/or without recording the clinical justification and/or contrary to the prescription guidelines. You therefore put patient 6 at risk of harm (charges 6 and 7).

- By virtue of the matters admitted and found proved and the matters found proved, including under charges 2, 4, 5 and 6, you put patients at risk of harm.

- Between 27 September 2021 and February 2022 you failed to maintain adequate standards of cross infection control in that you failed to ensure that the practice's decontamination procedures met the essential quality requirements of HTM 01-05 (charge 8a).

- You failed to ensure and/or check whether Colleague A had immunisations for and/or immunity to Hepatitis B before permitting Colleague A to be involved in clinical duties (including assisting chairside and carrying out decontamination procedures) (charge 8b)

- You failed to provide appropriate training to Colleague A in respect of the decontamination process (charge 8c).

- You failed to provide staff members with new clinical gloves that were fit for purpose (charge 8e).

- You instructed and/or permitted staff to re-use clinical gloves (charge 8f).

- You reused clinical gloves yourself that should have been "single use" (charge 8g).

- You instructed and/or permitted staff to use disposable facemasks for inappropriately long periods of time in breach of HTM 01-05 (charge 8h).

- You reused and/or instructed staff to reuse other single use items at the surgery, including disposable impression trays (charge 8i).

- You failed to provide your employees with an appropriate induction and failed to ensure that each member of your team had an appropriate DBS check prior to starting their employment (charge 9).

- You failed to treat members of the dental team with an appropriate level of respect and courtesy, as follows: (charge 10)

  - You made belittling comments to Colleague A on one or more than one occasion (charge 10(1) b)

  - You snatched alginate from Colleague A (charge 10(1) c).

- You were dismissive and/or rude and/or aggressive to Colleague B in January 2022 when Colleague B raised concerns about the running of the practice (charge 10(2)).

- You used foul language in front of dental colleagues on or around 20 October 2021 (charge 10(3)).

- You failed to ensure and/or check that all members of the dental team had appropriate training in relation to BLS (charge 11).

16 The Committee has considered each of the findings against you, as set out above. In respect of charge 2, concerning a failure to provide an adequate standard of care to 5 patients, the Committee has borne in mind the joint opinion of Professor Robb and Mr Holden, as set out in their report dated 8 October 2025, that this falls far below the standard expected of a reasonably competent general dental practitioner. They considered that there would be an unacceptable risk in administering sedation, as the lack of diagnostic assessments would not have allowed for the consideration of comorbidity, drug interactions and allergies, that are significant risk factors. The Committee is satisfied that this finding alone in itself is sufficiently serious to amount to misconduct.

17 Regarding charge 4 (record keeping) the experts considered that your failure to maintain an adequate standard of record keeping fell far below the standard expected of a reasonably competent general dental practitioner. The Committee has borne in mind that maintaining an adequate standard of record keeping is a fundamental requirement of a dentist and that the failings relate to several patients. The Committee is satisfied that the failings in relation to your record keeping amount to misconduct.

18 Turning to charge 5, both experts agreed that in failing to obtain valid consent, confirmed in writing, your conduct fell far below the standard expected of a reasonable General Dental Practitioner. Paragraph 22 of the GDC's Guidance states "the issue of informed or valid 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. Failure to obtain consent is a serious matter…". Although the finding related to a single patient, the Committee considered it sufficiently serious to amount to misconduct.

19 In respect of charge 6, Professor Robb's evidence was that, in relation to patient 6, your conduct fell below the standard expected relating to the prescription of metronidazole, as there was "no obvious reason from the notes to justify the prescription and the advice given to the patient was factually incorrect". As set out in its findings of fact, the Committee considered that there was no justification for the prescription of metronidazole and it was inconsistent with prescribing guidelines to prescribe the antibiotic without clinical justification. While Professor Robb considered that your conduct fell 'below' as opposed to 'far below' the expected standard, the Committee determined that the risk of harm to patient 6 made the conduct sufficiently serious to amount to misconduct.

20 The Committee is satisfied that given its findings that you placed patients at risk of harm by virtue of the matters set out in charges 2,4,5, 6, each of these findings is sufficiently serious to amount to misconduct. The findings relate to a number of patients concerning different aspects of clinical care where you put them at risk of harm. The Committee considers that the conduct underlying charge 7 is sufficiently serious to amount to misconduct.

21 Turning to your failure to maintain adequate standards of cross infection control (charge 8), the experts both agreed that your failure to do so falls far below the standard expected of a reasonably competent general dental practitioner. Mr Smyth and Mr Mulcahy considered that your non-compliance with basic cross infection control standards, as set out in each of the separate elements of charge 8, would amount to a falling far below the expected standard. The Committee considers that these findings are very serious, noting that your failures placed the public including patients and dental colleagues at risk of harm. The CQC raised significant and wide ranging concerns with you regarding fundamental aspects of infection control and your failure to adhere to HTM 01-05 guidance. The Committee considers that in your position as the owner and Principal of the Practice, you had a responsibility to ensure that the relevant guidance and standards were being adhered to. Notwithstanding the steps you took to address the concerns raised by the CQC, the Committee has concluded that the multiple findings in respect of charge 8 amount to a failure to comply with essential infection control requirements and are sufficiently serious to amount to misconduct.

22 Regarding your failure to provide your employees with an appropriate induction and your failure to ensure that each member of your team had an appropriate DBS check prior to starting their employment (charge 9), the Committee determined that you had a duty to ensure that these checks were done as Practice Principal and owner. Your failure to do so posed a risk to public safety as well as breaching GDC regulations and CQC standards. It is satisfied that this finding alone is sufficiently serious to amount to misconduct.

23 The Committee made several findings (charge 10) regarding your failure to treat members of the dental team with an appropriate level of respect and courtesy. The Committee noted that you gave evidence that you were going through a stressful period at the time of the events in question. In the Committee's judgement, making belittling comments to colleagues, speaking loudly and rudely to a colleague and using foul language in relation to patients, including the 'F-word' in front of dental colleagues, is unacceptable given your position as a registered dental professional and undermines public trust and confidence in the dental profession. The Committee had accepted the evidence of your colleagues who left the Practice, citing your behaviour as one of the reasons for leaving. The Committee considers that your behaviour fell far short of what would be proper and is sufficiently serious to amount to misconduct.

24 Finally, in respect of charge 11, you had a duty to ensure and/or check that patients were treated in a safe environment, including that all members of the dental team had appropriate training in BLS. The Committee considers that your failure in this regard placed patients at risk of harm and accepted the expert evidence that the matters set out at charge 11 fall far below the expected standard. It is satisfied that this finding is sufficiently serious to amount to misconduct.

25 In reaching its decision, the Committee considered that your conduct breached the following provisions of the GDC Standards For the Dental Team (September 2013):

Principle 1: Put patients' interests first

Standard 1.5: You must treat patients in a hygienic and safe environment

Standard 1.7: You must put patients' interests before your own or those of any colleague, business or organisation

Standard 1.9: You must find out about laws and regulations that affect your work and follow them.

Principle 2: Communicate effectively with patients

Standard 2.3: You must give patients the information they need, in a way they can understand, so that they can make informed decisions

Principle 3: Obtain valid consent

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

Principle 6: Work with colleagues in a way that is in patients' best interests.

Standard 6.1: You must work effectively with your colleagues and contribute to good teamwork.

Standard 6.5: You must communicate clearly and effectively with other team members and colleagues in the interests of patients.

Standard 6.6: You must demonstrate effective management and leadership skills if you manage a team.

Standard 7.1: You must provide good quality care based on current evidence and authoritative guidance.

Standard 8.3: You must make sure if you employ, manage or lead a team that you encourage and support a culture where staff can raise concerns openly and without fear of reprisal.

Principle 9: Make sure your personal behaviour maintains patients' confidence in you and the dental profession.

Standard 9.1: You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and in the public's trust in the dental profession.

26 The findings cover wide-ranging aspects of your clinical practice, your multiple failures in respect of infection control as well as your behaviour towards dental colleagues. The Committee has concluded that the findings against you amount to a falling short of what would be expected in the circumstances and that such falling short is serious. The Committee is satisfied that the findings against you, both individually, and collectively, amount to misconduct.

Committee's decision and reasons on impairment

27 The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. In doing so, it had regard to the over-arching 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. As such, it has had regard to the submissions made by both parties, all the documentation and it has accepted the advice of the Legal Adviser.

28 The Committee had regard to the case of CHRE V NMC & Grant in which Mrs Justice Cox referred to the approach to determining the issue of impairment formulated by Dame Janet Smith in her Fifth Report from Shipman. The test referred to is:

> "Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination 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 medical 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 medical profession; and/or
>
> d. ..."

29 The Committee was satisfied that limbs a, b and c were engaged in your case.

30 The Committee recognises, from the evidence before it, the steps you have taken to address the clinical concerns in this case, as set out in the charges against you. It notes the practical changes you introduced into your practice, the CPD you have undertaken, your engagement with your Workplace Supervisor, as well as the audits you have undertaken. The Committee notes that these changes occurred primarily during your conditional registration period. However, in the Committee's view you have not demonstrated an understanding of the potential consequences of carrying out treatment without adequate assessments, inadequate record keeping, prescribing without proper clinical justification or providing treatment without informed consent. Your reflections did not demonstrate any meaningful appreciation of why the failings were so serious.

31 Regarding infection control, the Committee was provided with evidence from you that the CQC had found you had remedied their concerns regarding cross-infection control by the time they conducted a re-inspection in May 2022. The Committee noted that these improvements were only made following the unannounced inspection in February 2022 where the CQC report had identified a significant number of failings. These failings were similar to concerns already raised by your colleagues and not remedied prior to the unannounced inspection.

32 Your cross-infection control failings were particularly concerning. These were not simply administrative oversights or failures. Instead, you personally re-used single use items and also instructed or permitted staff to reuse clinical gloves and other items, and permitted disposable masks to be used for inappropriately long periods. The Committee noted that this occurred during the period of the COVID-19 pandemic and undoubtedly the requirements for cross-infection control were still prominent. As a registered dental professional, with over 20 years' experience, you would have been fully aware of the

importance of adhering to fundamental standards of cross-infection control. Not doing so, in the Committee's view, demonstrated a disregard for public safety. The Committee has significant concerns about your lack of reflections and insight regarding the impact of your behaviour on patients and colleagues' safety. You also failed to demonstrate insight of this on public confidence in the profession and the maintenance of professional standards. You have failed to recognise the seriousness of your actions. The Committee was also concerned that you continued to suggest that aspects of the evidence given by the GDC witnesses had been exaggerated and that the concerns identified by the CQC had not been as extensive or serious as the allegations before the Committee. The Committee had assessed each allegation separately and had found allegations not proved where the evidence did not meet the required standard. Your continuing characterisation of the proved matters in this way reinforced its concern that you had not fully accepted their seriousness.

33 The Committee found that you failed to ensure that appropriate training, immunisation checks and safety arrangements were in place for your staff. As the owner and Principal of the Practice, you occupied a position of authority and trust and were responsible for ensuring that patients and staff were treated in a safe environment. You placed the blame for these matters on "lapses" or failures of the systems you had in place including in respect of the DBS checks and BLS training for staff. You did not demonstrate to the Committee any reflection adequately recognising your active role in the decisions and practices which had created the risks. Your statement that you would never knowingly or deliberately place patients or staff at risk was inconsistent with the Committee's findings and evidence produced that you allowed an inexperienced colleague to undertake clinical duties without the required checks and training. The Committee considers that you have shown a persistent lack of insight into the impact of such failures on the safety and well-being of the public in allowing staff to be employed without the necessary checks being carried out.

34 The Committee was also concerned by your persistent lack of insight into your conduct towards members of staff. The Committee noted that the misconduct was not confined to an isolated reaction on a single occasion but occurred over a period of time and affected several members of staff. Although you accepted the Committee's findings, you continued to describe your behaviour in terms of how it had been "perceived" by others as rude or abrupt. You also suggested that newer members of staff, who did not know about the difficulties in your personal life, may have been more prone to take offence. In the Committee's view, you sought to minimise responsibility or accountability in relation to those findings of belittling, rude and aggressive conduct. The Committee was not satisfied that your reflections demonstrated a sufficient understanding that, whatever pressures you were facing, you remained responsible for treating colleagues with respect and for maintaining a safe and professionally appropriate working environment.

35 The Committee considered the significant effect your conduct had on the working environment at the Practice and the impact this had upon your colleagues. Dentist A described experiencing immense stress and upset and considered that remaining at the Practice would risk damage to her professional reputation. Dental Nurse A described being horrified and deeply concerned by what she had observed and left because she was fearful of being associated with the Practice. Dental Hygienist A felt professionally compromised and unsafe and chose to make herself unemployed rather than continue working there. Colleague A described feeling anxious and stressed and stated that her experience had changed her wish to pursue a career in dentistry. Colleague A was a young and inexperienced trainee who was dependent upon you, as the owner and Principal, to provide appropriate training, supervision and support.

36 The Committee noted that the individuals concerned had left the Practice as a result of your behaviour and that despite the evidence concerning the effect upon those individuals, your reflections did not meaningfully address their experiences or demonstrate an understanding of how your conduct and management had affected their confidence, well-being and professional standing.

37 The Committee was not satisfied that your response amounted to an acknowledgment of the seriousness of its findings. Your reflections focused mainly upon the effect of the proceedings and findings upon you, including the shame you felt at the Committee having "determined me to be guilty of such conduct", the length and difficulty of the regulatory process and the possible effect upon the confidence of your existing patients. There was minimal consideration of the effect of your actions upon those who had worked for you, on public safety and the impact on public confidence in the profession.

38 You were entitled to defend yourself and to require the GDC to prove its case. The fact that you did not admit allegations which were later found proved does not count against you. However, in terms of your reflection at this stage of the proceedings, the Committee noted that you had now heard the evidence of your former colleagues, had received the Committee's detailed findings and had been provided with a further opportunity to reflect upon them. Your reflections did not acknowledge the impact of such actions upon colleagues or your responsibility for creating the circumstances in which they felt unable to remain at the Practice.

39 The events occurred predominantly in late 2021 and early 2022. You have therefore had approximately four years in which to reflect upon them. During that period, the concerns were raised by colleagues, investigated by the CQC, made the subject of interim conditions and addressed during approximately three years of workplace supervision. You subsequently heard the evidence during this hearing, received the Committee's findings and provided a stage two bundle comprising approximately 460 pages, together with oral evidence.

40 Despite this timeframe and opportunity, your reflections remained principally directed towards correcting procedures and demonstrating present compliance. They did not satisfactory address your personal responsibility, the seriousness of the risks created, the effect upon the individuals concerned or the professional attitude underlying the misconduct.

41 The Committee therefore assessed your insight as persistently lacking. It accepted that you had developed some awareness that changes were required and that the allegations and findings could affect the trust placed in you. However, it was not satisfied that you had reached a genuine understanding of why your conduct was wrong, why it presented a significant risk of harm or how it affected patients and colleagues. Your expressions of remorse and apology did not demonstrate the depth of accountability that the Committee would have expected after the passage of time and the extensive opportunities for reflection.

42 The Committee was consequently not satisfied that the underlying causes of the misconduct had been adequately identified or remediated. Although the practical clinical processes have changed, the professional attitudinal concerns remain. In the absence of insight into those matters, and the associated risks of harm, the Committee determined that there remains a real risk of repetition of unwarranted risk of harm to the public, including patients and colleagues. Accordingly, the Committee determined that your fitness to practise is currently impaired on the ground of public protection.

43 The Committee also considered the wider public interest. The misconduct involved serious and wide-ranging departures from fundamental professional standards. These included failures relating to sedation, record keeping, consent, antibiotic prescribing, cross-infection control, staff checks and training, and the treatment of colleagues. The infection-control findings were a considerable departure from published requirements and involved basic measures intended to protect patients and staff from exposure to infectious diseases and was intrinsic to your fundamental professional obligation to provide dental care in a safe and hygienic environment. The Committee found that your misconduct brought the profession into disrepute and breached fundamental tenets of the profession. Having found that you have persistently lacked insight, including into the reputational impact on the profession of your conduct and ongoing attitudinal concerns, the Committee determined that you are liable in the future to repeat this behaviour.

44 The Committee considered that an informed member of the public would be seriously concerned if such misconduct did not result in a finding of impairment, particularly where you had not demonstrated sufficient insight or accountability. In the Committee's judgment, a finding of impairment is necessary to maintain confidence in the dental profession and in the regulatory process and to declare and uphold the standards expected of registered dental professionals.

45 Accordingly, the Committee determined that your fitness to practise is currently impaired by reason of your misconduct on both public protection and wider public interest grounds.

Sanction

46 The Committee considered what sanction, if any, to impose on your registration. The purpose of a sanction is not to punish, although it may have that effect, but to protect the public and safeguard the wider public interest. The Committee had regard to the GDC's Guidance and applied the principle of proportionality, balancing the need to protect patients, maintain public confidence and uphold professional standards against your own interests.

47 The Committee considered the mitigating and aggravating features of the case. In mitigation, it took account of:

- your personal and family circumstances at the time of the events;
- the practical steps you have taken to address the clinical concerns; and
- no fitness to practise history.

48 The Committee accepted that you were experiencing significant personal difficulties during the relevant period and gave those circumstances some weight. However, it considered that their mitigating effect was limited. The conduct occurred over an extended period, involved several distinct aspects of your clinical and managerial responsibilities and affected a number of patients and colleagues. Your circumstances did not explain or excuse the full extent of the misconduct, as indeed you recognised in your submissions.

49 The Committee recognised the changes to your sedation, consent, prescribing, record-keeping and infection-control procedures, your CPD, the audits completed and the evidence of improved compliance identified during the subsequent CQC inspection. It also took account of your compliance with the interim conditions for a period of approximately three years.

50 However, the weight the Committee attached to those matters was considered alongside the fact that the improvements followed external intervention by the CQC and the imposition of interim conditions. Moreover, the practical remediation did not address the Committee's continuing concerns about your professional attitude, persistent lack of insight and accountability.

51 The Committee identified the following aggravating factors:

- the significant risk of harm created for patients and members of staff;
- breach of trust;
- your position of authority as the owner and Principal of the Practice;
- the misconduct occurred repeatedly and across several areas of professional practice; and
- your persistent lack of insight into the seriousness, impact and potential consequences of your conduct.

52 In the Committee's view, you had prioritised your personal motivation for expanding your business and increasing your Practice's social media presence over putting your patients' best interests first. This included reusing single-use items with disregard to the safety of patients and staff.

53 The Committee had regard to the supportive testimonials submitted on your behalf. It was clear that their authors consider you to be a highly regarded and clinically competent dentist. The Committee also took account of the positive patient reviews and the evidence that you had undertaken complex dental work without other reported concerns. However, the Committee considered these in the context of the serious findings made and your persistent lack of insight which it had identified.

54 The Committee considered the available sanctions in ascending order of severity. It first considered taking no action. The case was plainly not exceptional and taking no action would neither protect the public nor address the wider public interest.

55 The Committee next considered a reprimand. A reprimand would not restrict your ability to practise and would be appropriate only where the identified risk was sufficiently low and the misconduct could adequately be marked without restriction. Given the continuing risk of repetition, your persistent lack of insight and the serious and wide-ranging nature of the misconduct, a reprimand would be insufficient to protect the public, maintain public confidence or uphold professional standards.

56 The Committee then considered conditions of practice. It bore in mind that conditions must be sufficient, workable, measurable, enforceable and capable of addressing the identified risk. It also took account of your previous compliance with interim conditions and the practical improvements made during that period.

57 However, the position before this Practice Committee is materially different from that before the Interim Orders Committee. Detailed findings of fact have now been made and the Committee has concluded that impairment of your fitness to practise is not confined to deficiencies in clinical knowledge or procedure. It also encompasses your professional attitude, your limited acceptance of personal responsibility, your treatment of colleagues and your failure to appreciate the seriousness of the risks created.

58 The Committee could not formulate conditions which would adequately address those concerns. Further training, supervision or auditing might monitor clinical processes, but would not ensure that you had developed the necessary insight or professional attitudes. The Committee also considered that conditions would not be sufficient to mark the seriousness of the misconduct or satisfy the wider public interest. Even if conditions were capable of being formulated, they would not be a proportionate response to the seriousness of your misconduct.

59 The Committee therefore concluded that conditions of practice were insufficient and proceeded to consider suspension. By reference to the factors indicated in support of suspension in the GDC's Guidance, the Committee recognised that suspension is appropriate in serious cases and would remove you from practice for a period, thereby providing protection to the public. It identified that patients' and colleagues' interests would be insufficiently protected by a lesser sanction and that public confidence would also be insufficiently maintained by a lesser sanction.

60 The Committee carefully considered whether a period of suspension, with a review, would provide you with a further opportunity to develop insight and demonstrate that the attitudinal concerns had been remediated. It acknowledged the practical changes you had made and considered whether these might represent the beginning of a process of remediation which could be completed during a period of suspension.

61 However, the Committee concluded that suspension would not be sufficient. Your remediation had largely concerned procedures, documents, audits and compliance with external requirements. Despite the passage of approximately four years, the involvement of the CQC, approximately three years of workplace supervision under the interim order, the evidence heard during the proceedings and the opportunity to provide extensive written and oral reflections, you have not demonstrated an understanding of the central concerns.

62 The Committee was particularly concerned at your persistent lack of insight into the seriousness of the actions or consequences of instructing or permitting unsafe infection-control practices and placing Colleague A, a trainee dental nurse, in a position where she was required to work without appropriate checks, training or protection. Nor had you demonstrated understanding of the impact of your conduct upon those colleagues who experienced stress, felt professionally compromised and left the Practice.

63 These were not isolated clinical deficiencies which could readily be addressed through further CPD. They reflected a serious professional attitudinal problem involving your approach to patient and staff safety, your responsibilities as an employer and Principal, and your treatment of colleagues who raised concerns.

64 The Committee considered that you have a persistent lack of insight. It has seen no evidence of insight that would provide a proper basis for concluding that a period of suspension would bring about the fundamental attitudinal changes. Having regard to the length of time which has already passed, the Committee was not satisfied that suspension would result in the necessary development of insight or remediation.

65 The Committee also considered that suspension would not adequately maintain public confidence or uphold professional standards. The seriousness of the infection-control failings, your active role in the unsafe practices, the risks created for patients and staff, the conduct towards colleagues and the persistent lack of insight meant that a temporary removal from practice would not properly reflect the gravity of the case.

66 The Committee therefore considered erasure. It had regard to the relevant factors identified in the GDC's Guidance and found the following to be present:

- serious departures from fundamental professional standards;
- a continuing risk of harm to patients and colleagues;
- an abuse of the position of trust and authority you held as owner and Principal of the Practice; and
- a persistent lack of insight into the seriousness and consequences of your conduct.

67 The Committee considered that the obligation to provide treatment in a hygienic and safe environment is fundamental to dental practice. Your conduct did not consist solely of failing adequately to supervise a system operated by others. You personally re-used single use items and instructed or permitted staff to reuse items intended for single use and failed to ensure that Colleague A had the necessary immunisation checks, training and protection before undertaking clinical duties. This conduct was fundamentally inconsistent with your responsibilities as a dentist and practice owner.

68 The seriousness of those matters was compounded by your persistent lack of insight. The Committee concluded that your conduct is fundamentally incompatible with continued registration. An informed member of the public would be seriously troubled if a dentist who had engaged in such serious and wide-ranging misconduct, and who had not developed sufficient insight despite extensive time and opportunity, were permitted to remain on the Register.

69 The Committee carefully considered the substantial impact erasure will have upon you. It recognised that you will be unable to practise as a dentist in the United Kingdom and that the outcome may have wider consequences for any employment you may seek overseas. It also took account of your lengthy career, your previous good regulatory history, the supportive testimonials, the practical remediation undertaken and the personal difficulties you experienced. However, it concluded that your interests are outweighed by the need to protect the public, maintain public confidence in the dental profession and declare and uphold proper professional standards. No lesser sanction would adequately meet those objectives.

70 Accordingly, the Committee directs that the name of Jenefar Mosfie Kabir (79194) be erased from the Register.

71 The Committee now invites submissions on the question of an immediate order.

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72 The interim order on your registration is hereby revoked.

73 Mr Greany applied for an immediate suspension order under section 30(1) of the Dentists Act 1984 (the 'Act'). He submitted that such an order is necessary for the protection of the public and is otherwise in the public interest.

74 Mr Sheldon made no submissions.

75 The Committee accepted the advice of the Legal Adviser on its power to make an immediate order.

76 The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to order that your registration be suspended immediately under section 30(1) of the Act. The Committee has found a continuing risk of harm to the public and has also found that you have demonstrated conduct which is fundamentally incompatible with continued registration. It would be inconsistent with the determination the Committee has reached not to make an immediate order.

77 The effect of this immediate order is that your registration is now suspended. Unless you exercise your right of appeal, your name shall be erased from the Register upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

78 That concludes the case.