GENERAL DENTAL COUNCIL

AND

SPRY, Marcus Edwin

[Registration number: 60862]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council, commencing at 10:00am on Monday 2 November 2026, to be held at:

Dental Professionals Hearings Service
Avon House,
Avonmore Road,
West Kensington,
London,
W14 8TS

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

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

Committee members:

Joanne Brindley	DCP	Chair
Suki Sandhar	Dentist	
Clive Powell	Lay	

Legal Adviser:

Emma Boothroyd	Legal Adviser

CHARGE

SPRY, Marcus Edwin, a dentist, BDS Lond 1985, is summoned to appear before the Professional Conduct Committee on Monday 2 November 2026 for an inquiry into the following charge:

The Charge

The hearing will be held to consider the following charge against you:

"That being a registered dentist,

A. You practised as a dentist at the dental practice referred to in Schedule 1 below ("the Practice") and treated the patients listed below (and referred to in Schedule 1 below).

B. You failed to provide an adequate standard of care from 7 May 2009 to 20 December 2023, for Patients A to I and Patients 1 to 58, in that:

Patient A

1. You provided a poor standard of treatment to Patient A, in that:

    a. During an appointment on 25 January 2021:

        i. you provided a bridge that inappropriately linked Patient A's UL4 implant and their UL6 natural tooth;
        ii. you provided a bridge that inappropriately linked Patient A's LL5 root filled tooth to their LL6 implant;
        iii. you provided a crown at Patient A's LL5 with deficient margins.

2. During an appointment on 12 September 2023, you:

    a. did not report on the periapical radiograph taken, covering Patient A's UL2 implant;
    b. did not diagnose and/or offer any treatment for, bone loss found at Patient A's UL2 implant;

[…]

Patient B

4. During an appointment on 16 October 2017, in advance of placing an implant at Patient B's UR1, you did not:

    a. conduct an adequate assessment of the amount of bone available for implant placement;
    b. inform Patient B of the risk of perforation of the nasal floor when placing an implant at their UR1.

5. During an appointment on 16 October 2017, you did not detect that the implant you had placed at Patient B's UR1 had entered their nasal cavity.

6. You did not take any radiograph covering Patient B's UR1 dental implant, in-between placing the implant, on 16 October 2017, and fitting the implant crown, on 13 February 2018.

7. During an appointment on 26 May 2018, you did not:

    a. report on the periapical radiograph taken;
    b. inform Patient B that the implant you had previously placed at their UR1 had entered their nasal cavity.

8. During an appointment on 1 June 2019, you did not:

    a. report on the periapical radiograph taken;
    b. inform Patient B that the implant you had previously placed at their UR1 had entered their nasal cavity.

9. Your conduct in Charge 7.b. and/or 8.b. was:

    a. misleading;
    b. lacking in integrity;
    c. dishonest – in that you knew the implant you had place at Patient A's UR1 had entered their nasal cavity and you had a duty to inform them about such.

10. By reason of your conduct in Charge 4.b. you failed to obtain Patient B's informed consent for the implant placed at their UR1.

Patient D

11. During an appointment on 17 December 2020, you did not adequately report on a CBCT scan.

[…]

Patient E

13. During an appointment on 29 January 2019, you:

    a. provided a poor standard of treatment to patient E, in that the implant you placed at their UR3 was malpositioned;
    b. did not recognise that the implant you had placed at their UR3 was malpositioned and/or provide Patient E with any options to manage this outcome.

14. During an appointment on 27 September 2023, you did not conduct an adequate investigation of Patient E's implants, in that you did not check the peri-implant pockets with a periodontal probe to assess:

a. pocket depth;
b. whether there was any discharge.

Patient F

15. You did not adequately discuss the heightened risks associated with implant treatment when suffering from periodontitis, in advance of placing implants at Patient F's:

    a. UR1, on 18 December 2014;
    b. UR7, on 18 June 2015.

16. During an appointment on 19 September 2019, you did not diagnose and/or offer any treatment for peri-implantitis found at Patient F's UR1.

17. You did not adequately monitor and/or manage peri-implantitis, found at Patient F's UR1, between 19 September 2019 and 12 December 2019.

    […]

19. By reason of your conduct in Charge 15.a. you failed to obtain Patient F's informed consent for the implant placed at their UR1.

20. By reason of your conduct in Charge 15.b. you failed to obtain Patient F's informed consent for the implant placed at their UR7.

Patient G

21. You did not diagnose bone loss around Patient G's UL4 implant during an appointment on:

    a. 13 July 2022;
    b. 10 August 2022.

22. You did not inform Patient G about bone loss around their UL4 implant and the poor prognosis of this implant, during an appointment on:

    a. 13 July 2022;
    b. 10 August 2022.

23. During an appointment 10 August 2022, you provided a poor standard of treatment, in that you inappropriately used Patient G's UL4 implant to support a bridge.

24. By reason of your conduct in Charge 22. you failed to obtain Patient G's informed consent for the bridge you placed on 10 August 2022.

Patient H

25. Between 25 March 2021 and 19 May 2023, you did not:

a. adequately assess Patient H's occlusion;
b. adequately assess and/or manage Patient H's tooth-wear;
c. adequately manage Patient H's occlusion when planning restorations.

26. During an appointment on 25 October 2022, you provided a poor standard of treatment, in that, the implant you placed at Patient H's UR2 was poorly positioned.

    […]

Patient I

28. You provided a poor standard of treatment to Patient I, in that:

    a. during an appointment on 21 August 2015, you placed an implant at Patient I's LL4 at a distance of 1 millimetre from their LL3;
    b. during an appointment on 22 September 2015, you provided a bridge linking Patient I's LL3 with an implant at their LL6.

29. During an appointment on 20 September 2021, you did not diagnose and/or offer to treat, bone loss around Patient I's UL5 implant.

Patient 1

30. During an appointment on 27 February 2023, you did not take a radiograph covering Patient 1's LL2 and LR2.

31. During an appointment on the 11 May 2023, you did not:

    a. adequately report on a periapical radiograph taken;
    b. identify that Patient 1's LL2 implant was unlikely to be successful.

Patient 4

32. During an appointment on 10 February 2023, you prescribed antibiotics without an adequate clinical justification.

Patient 7

33. During an appointment on 21 December 2020 you:

    a. did not discuss the risks and benefits of undertaking root canal treatment (RCT), at Patient 7's UL1, in advance of doing so;
    b. carried out root canal treatment (RCT), on Patient 7's UL1, without using a rubber dam.

34. You prescribed antibiotics without an adequate clinical justification on:

    a. 18 December 2020;
    b. 21 December 2020;

c. 11 January 2021.

Patient 13

35. You prescribed antibiotics without an adequate clinical justification on:

    a. 21 September 2019;
    b. 24 August 2020;
    c. 5 February 2021.

36. You did not adequately update Patient 13's medical history, in that, you did not record Patient 13 was taking Methotrexate from 21 September 2019 to 4 March 2021.

Patient 15

37. You prescribed antibiotics without an adequate clinical justification on:

    a. 12 December 2022;
    b. 17 January 2023;
    c. 8 February 2023;
    d. 17 February 2023.

Patient 17

38. You did not provide any periodontal treatment for Patient 17's periodontal disease between 13 September 2022 and 14 June 2023.

Patient 19

39. During an appointment on 9 November 2021, you did not:

    a. Report on a bitewing radiograph taken;
    b. Diagnose the presence of bone loss.

Patient 23

40. You provided a poor standard of treatment to Patient 23, during an appointment on 6 January 2014, in that:

    a. the implants you placed at their UR2 and UR1 were less than 3mm apart;
    b. the implant you placed at their UR2 was less than 3mm from their UR3 tooth.

41. You did not diagnose and/or manage chronic periodontitis, between 1 August 2012 and 13 February 2014, before placing an implant at Patient 23's LL1 on 13 February 2014.

42. You did not identify and/or manage failing implants, at Patient 23's UR2 and/or UR3, from 22 March 2017 to 3 July 2023.

43. You did not adequately manage, and/or inform Patient 23 about, peri-implantitis found around their LL3 and LR3 implants, from 16 January 2020 to 19 January 2023.

44. You provided a poor standard of treatment to Patient 23, during an appointment on 23 February 2023, in that, you did not place mini-implants at their LR3 and/or LL3, having commenced surgery to do so.

45. You did not diagnose and/or treat caries and periodontitis at Patient 23's LR3 to LR1, from 15 May 2014 to 30 April 2015.

46. You did not undertake an adequate periodontal assessment until 6 September 2016.

47. You did not adequately assess and/or treat periodontal disease, between 7 May 2009 and 3 July 2023.

48. You did not report on radiographs taken on:

    a. 18 June 2009;
    b. 18 January 2010;
    c. 19 August 2010;
    d. 27 June 2013;
    e. 13 December 2014;
    f. 6 May 2014;
    g. 2 October 2015;
    h. 16 January 2020.

Patient 30

49. You prescribed antibiotics without an adequate clinical justification on 1 March 2023.

Patient 35

50. You did not diagnose and/or offer to treat peri-implantitis, found at Patient 35's LL6 implant, from 24 October 2019 to 1 February 2022.

51. You provided a poor standard of treatment to Patient 35, during an appointment on 4 January 2022, in that, you placed a post at their LL7 which perforated the tooth.

Patient 36

52. During an appointment on 19 November 2020, you carried out RCT, on Patient 36's UL7, without using a rubber dam.

Patient 39

53. During an appointment on 5 January 2022, you carried out RCT, on Patient 39's UL7, without using a rubber dam.

Patient 41

54. You did not discuss with Patient 41, the option of retaining some of their teeth in advance of providing implant treatment on 26 January 2022.

55. By reason of your conduct in Charge 54. you failed to obtain Patient 41's informed consent for the implant treatment you provided.

Patient 42

56. During an appointment on 16 March 2023, you prescribed antibiotics:

    a. without an adequate clinical justification;
    b. that Patient 42 was allergic to.

57. Your conduct in Charge 56.b. placed Patient 42's safety at risk.

Patient 46

58. You did not adequately assess Patient 46 and/or the CT scan you had taken on 24 February 2022, prior to placing an implant at their UL5 on 7 March 2022.

59. During an appointment on 7 March 2022, you provided a poor standard of treatment to Patient 46, in that, half of the UL5 implant length, was placed in their sinus cavity.

60. You did not adequately report on radiographs taken on:

    a. 7 March 2022;
    b. 30 June 2022;
    c. 22 August 2023.

61. You did not inform Patient 46 that the implant placed at their UL5 was likely to fail, during appointments on:

    a. 7 March 2022;
    b. 30 June 2022;
    c. 22 August 2023.

Patient 47

62. During an appointment on 7 December 2021, you did not discuss the risks of and/or the alternative treatment options to, the orthodontic treatment provided.

63. By reason of your conduct in Charge 62. you failed to obtain Patient 47's informed consent for the orthodontic treatment you provided.

Patient 48

64. During an appointment on 13 March 2020, you prescribed Patient 48 with a tooth whitening product.

65. Your conduct in Charge 64. was in breach of '*The Cosmetic Products enforcement Regulations 2013.'*

Patient 49

66. You prescribed antibiotics without an adequate clinical justification, on 3 February 2023.

Patient 50

67. During an appointment on 21 February 2023, you did not:

    a. conduct a Basic Periodontal Examination (BPE);
    b. inform Patient 50 about bone loss in their lower arch.

68. You did not provide any periodontal treatment, from 21 February 2023 to 4 July 2023.

Patient 51

69. During an appointment on the 19 October 2022, you did not:

    a. recognise that the source of infection at Patient 51's LL3 was a failed implant;
    b. remove the implant at Patient 51's LL3, in order to drain the infection present;

70. You prescribed antibiotics without an adequate clinical justification, on:

    a. 18 July 2022;
    b. 22 July 2022;
    c. 21 September 2022;
    d. 19 October 2022;
    e. 27 October 2022.

Patient 52

71. You carried out RCT, on Patient 52's UL4, without using a rubber dam on:

    a. 4 January 2023;
    b. 6 January 2023.

Patient 56

72. During an appointment on 9 February 2023, you:

a. carried out RCT, on Patient 56's LL6, without using a rubber dam;
b. prescribed antibiotics without an adequate clinical justification.

Patient 57

73. Between 11 May 2021 and 13 October 2022, you did not:

    a. provide Patient 57 with adequate oral hygiene instructions;
    b. offer to remove plaque;
    c. inform Patient 57 about the presence of bone loss around their upper molar teeth.

74. You did not conduct an adequate periodontal assessment during an appointment on 13 October 2022.

75. In advance of placing implants on 23 November 2022, you did not contact Patient 57's medical doctor, to discuss the treatment you proposed.

76. Your conduct in charge 75. placed Patient 57's safety at risk.

Patient 58

77. You did not inform Patient 58 that they had periodontitis and the impact that this could have on implant treatment, on or after 2 December 2022.

78. You did not carry out adequate periodontal treatment, between 2 December 2022 and 13 July 2023.

Cross Infection Control concerns

79. You failed to maintain adequate standards of cross infection control, in that:

    a. On an occasion when Dental Nurse 1 was assisting you, during the course of dental treatment, you left your surgery wearing bloodied gloves and touched doors and/or door handles within Practice A whilst still wearing these gloves;

    b. during an appointment on 2 August 2023, you used a screwdriver to remove one or more implant caps from Patient 41's mouth, that had not been properly sterilised.

80. Your conduct in Charge 79.a. placed patient safety at risk.
81. Your conduct in Charge 79.b. placed Patient 41's safety at risk.

Misleading communications with Patients

82. On or around 9 August 2023, after the GDC had commenced a fitness to practice investigation against you, you sent a letter to patients which stated: "*As part of their (the GDC's) role, they occasionally review patient records…these checks are routine from time to time"*

83. On or around 3 September 2023, after the GDC had commenced a fitness to practice investigation against you, you sent a letter to patients which stated: *"The matter is an internal audit issue that has to have a letter sent to you…the GDC has a legal right to examine notes of patients and they occasionally do."*

84. Your conduct in Charge 82. and/or 83. was:

    a. misleading;
    b. lacking in integrity.

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