PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

1-22 June 2026

Name:	BROWN, Paul Jeremy
Registration number:	65549
Case number:	CAS-205233

General Dental Council:	Natasha Tahta of Counsel Instructed by Alexander Wilson of Capsticks
Registrant:	Present Anthony Haycroft of Counsel Instructed by Stephen Hooper of Clyde and Co.

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension with a review
Period:	12 months
Immediate order:	Immediate suspension order

Committee members:	Carson Black	(Chair) (Dentist)
	Clare Mcilwaine	(DCP)
	Aleena Choudhry	(Lay)
Legal adviser:	Richard Ferry-Swainson	
Committee Secretary:	Paul Carson	

The Charge (as amended)

BROWN, Paul Jeremy, LDS Royal College of Surgeons Of England 1990 was summoned to appear before the Professional Conduct Committee on 1 June 2026 for an inquiry into the following charge:

"That being a registered dentist:

Patient 1

1. You failed to provide an adequate standard of care to Patient 1 between 12 April 2022 and 29 April 2022 in that you failed to take sufficient radiographs:

    a. before commencing root canal treatment at LL3;

    b. after providing root canal treatment at LL3;

    c. before preparing the teeth for a 7 unit bridge.

2. You failed to discuss the full risks and benefits of the 7 unit bridge with Patient 1 on 12 April 2022 .

3. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments between 5 February 2018 and 29 April 2022

4. You failed to obtain informed consent from Patient 1 between 12 April 2022 and 29 April 2022 for:

    a. root canal treatment at LL3;

    b. a 7 unit bridge.

Patient 2

5. You failed to provide an adequate standard of care to Patient 2 between 2 November 2021 and 6 December 2021 in that you:

    a. failed to take a pre-operative radiograph of the UR5 and/or the UR4 prior to performing an apicectomy;

    b. provided an apicectomy at the UR5 and/or the UR4 when there was an inadequate root canal filling.

6. You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments between 20 March 2019 and 11 March 2022.

7. You failed to obtain informed consent from Patient 2 for an apicectomy at the UR5 and/or the UR4 between 2 November 2021 and 6 December 2021.

8. You failed to:

    a. maintain adequate processes

    b. ensure adequate processes were followed

    to identify and remove out of date Midazolam in the medical emergency drug box between 1 May 2017 and 6 October 2017.

9. Your conduct at allegation 8 put patient safety at risk.

10. You caused a letter, dated 9 May 2022, to be sent to patients, in which you stated that:

    a. Colleague A had "*stolen data*" from the practice;

    b. Colleague A had been dismissed from the practice *"the moment he stole patient details*".

11. The statements at allegation 10 a and/or b above were incorrect.

12. For a period of time up to and including at least 9 May 2023, you have stated the following on your Practice website:

    a. "*New 3D very low Dose Xray Machine. We are the only practice in Suffolk to have invested in this essential state of art technology*";

    b. "*Paul Brown is one of the UK's most experienced implant dentists having placed many of hundreds of implants and their fixtures during his career so far".*

13. The statements at allegation 12 a and/or b above were incorrect.

14. Your conduct at allegations 10 and/or 12 above was:

    a. misleading;

    b. dishonest.

15. You failed to treat a colleague with respect, between March 2021 and December 2022, in that:

    a. you insisted that Colleague B should use an English name, [REDACTED]

rather than her real name, [REDACTED], whilst at work:

b. you insisted that other members of staff should refer to Colleague B as [REDACTED] rather than her real name, [REDACTED];

c. you addressed Colleague B in emails as [REDACTED] despite her signing off her emails to you as [REDACTED];

d. you informed Colleague B that patients would not respect her if she used her real name;

e. you told Colleague B when she had days with lots of patients that it was because she had changed her name to [REDACTED].

16. You failed to treat a colleague with respect in that, between April 2021 and March 2022, you repeatedly made comments about Colleague C's size:

a. in front of colleagues;

b. in front of patients.

17. You failed to treat colleagues with respect in that,

a. at a team meeting in or around September 2021, in front of colleagues, you shouted at Colleague C and called him stupid, or words to that effect;

b. on or around 4 May 2021, you shouted at one or more colleagues in a meeting regarding a face mask having been discarded in the wrong bin;

c. on or around 11 May 2021, you shouted at one or more colleagues in a meeting regarding rescheduling of patients' appointments;

d. on or around 11 May 2021, on another occasion, you shouted at Colleague D regarding her rescheduling of a patients' [sic] appointment;

e. on or around 10 March 2022, you called Colleague C "bloody stupid", or words to that effect, when he insisted that a dental handpiece should be sterilized.

18. In or around May 2022, you failed to treat a colleague with respect in that, in front of a patient:

a. you insisted that Colleague C should put a belt on that was too small for him;

b. you told Colleague C "*I'm going to give you six months for this to fit*", or words to that effect.

19. In or around 2021 you made inappropriate comments to colleagues and/or patients, in that you:

    a. stated to one or more colleagues that they should refer to Colleague E as [REDACTED] *as "no one would have trust in a* [REDACTED]" or words to that effect;

    b. stated to one or more patients that an individual had walked out to a boxing match to "*Nigger black music*" or words to that effect;

    c. stated to one or more colleagues "*Do you know who make the best practice owners? Poofs*" or words to that effect;

    d. stated to Colleague A that Patient 3 was a "*coffin dodger*" or words to that effect.

20. Your conduct at allegations 15 a - e and/or 19 a and/or b above was (a) offensive; and/or (b) racially motivated.

21. Your conduct at allegation 19 c was (a) offensive; and/or (b) homophobic.

22. Between 27 September 2021 and 24 May 2022, you submitted or allowed to be submitted claims to the NHS in your performer number for dental treatment carried out by Colleague F.

23. Between 27 September 2021 and 24 May 2022, you caused and/or permitted Colleague F to treat NHS patients whilst he did not have an NHS performer number and was not on the NHS performers list.

24. Your conduct in respect of 22 and/or 23 above was dishonest in that you intended to give the NHS the impression that you had carried out NHS funded dental treatment when you had not.

25. Alternatively, your actions in 22 and/or 23 above were misleading in that the NHS were misled into thinking you had carried out dental treatment funded by the NHS when you had not.

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

Mr Brown,

1. You qualified as a dentist in 1990 and became the principal of your own practice in 1997 from where you continue to work. In 2006 you also acquired a second practice. For ease of drafting, the Committee shall refer to either or both practices simply as the practice.

2. The allegations against you concern your clinical care, record keeping and consent in relation to two patients in 2021/22; your practice governance in respect of emergency medication stock; an incorrect statement made by you to patients regarding the circumstances of a data breach; incorrect statements on your practice website relating to practice equipment and your level of expertise in implant dentistry; your conduct towards colleagues; alleged offensive or discriminatory comments; and NHS claims submitted under your performer number for treatment carried out by another dentist.

3. Much of the factual allegations were broadly admitted by you, with the principal matters in dispute going largely to context and state of mind. For example, among other matters, whether a phrase said by you to the effect of *"Do you know who make the best practice owners? Poofs"* was homophobic; whether your insistence that a dentist at the practice anglicise her patient facing name from [REDACTED] to [REDACTED] was racially motivated; whether and to what extent your admitted use of the "N"-word was in front of patients; whether you had confined your use of that term to explaining the name of a band and whether your use of the term was in any event racially motivated; whether various incorrect statements made by you to patients and on your practice website were dishonest; and whether submitting claims under your performer number for treatment carried out by another dentist was dishonest.

Procedural progress

4. At the outset of the hearing on 1 June 2026, Ms Tahta, on behalf of the General Dental Council (GDC), applied under Rule 25 of the General Dental Council (Fitness to Practise) Rules 2006 (the "Rules") for additional allegations to be joined to those which had already been referred by the Case Examiners and which were of a similar kind and arose from the same facts as the allegations which had already been referred. The additional allegations which Ms Tahta applied to be joined were that:

5. you failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments within the period from 5 February 2018 until 29 April 2022;

6. you stated to one or more colleagues that Colleague E should be referred to as [REDACTED] as "no one would have trust in a [REDACTED]", or words to that effect;

7. your conduct, set out in previous charges, was racially motived; and

8. your conduct, set out in a previous charge, was homophobic.

9. Ms Tahta also applied for consequential amendments under Rule 18 of the Rules to plead that your conduct was also or alternatively "offensive" and to correct the date in charge 18 from "March 2022" to "May 2022".

10. These applications were unopposed by Mr Haycroft on your behalf.

11. The Committee, having accepted the advice of the Legal Adviser on these matters, acceded to the joinder and amendment. The Committee was satisfied that these additions and amendments had been properly notified to you, were in the interests of justice and that no prejudice or injustice would be caused to either party.

12. A further unopposed amendment to the Charge was made later in the proceedings to correct a minor typographical error.

13. As part of its factual inquiry, the Committee heard oral evidence from the following factual witnesses called by the GDC:

- Colleague A, a dentist and former associate at your practice who you alleged had "stolen" patient data;
- Colleague B, a dentist and former associate at your practice who was required by you to anglicise her name to [REDACTED];
- Colleague C, a former dental nurse at your practice to whom you are alleged to have made inappropriate comments;
- Colleague D, a former dental hygienist at your practice at whom you are alleged to have shouted in relation to the disposal of a face mask and the rescheduling of a patient appointment;
- Colleague F, a dentist and former associate at your practice whose work was claimed for under your NHS performer number.

14. The Committee also heard expert opinion evidence from Mr B. Dhami BDS Hons (Manc), MSc Dist (UCL Eastman), PGCME (Dundee) and Prof. N. Barker BDS MSc FCGDent FDSRCS FHEA MDTFEd PGCertMedEd, instructed on behalf of the GDC and on your behalf respectively.

15. The Committee also heard oral evidence from you and from your Practice Manager at the time.

16. The Committee also had regard to the agreed witness statements contained in the bundles and took these statements as read, without requiring those witnesses to be called.

17. The Committee had regard to the submissions made by both Counsel.

18. The Committee accepted the advice of the Legal Adviser.

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

20. The Committee took into account that you are a man of good character.

Findings 16 June 2026

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

	Patient 1
1.	*You failed to provide an adequate standard of care to Patient 1 between 12 April 2022 and 29 April 2022 in that you failed to take sufficient radiographs:*
1.(a)	*before commencing root canal treatment at LL3;* **Admitted and found proved.**
1.(b)	*after providing root canal treatment at LL3;* **Admitted and found proved.**
1.(c)	*before preparing the teeth for a 7 unit bridge.* **Admitted and found proved.**
2.	*You failed to discuss the full risks and benefits of the 7 unit bridge with Patient 1 on 12 April 2022.* **Proved.** Patient 1 was aged 89 at the time she attended and received root canal treatment at LL3 and a seven-unit bridge. You said she was suffering from cancer and died approximately nine months later. As pleaded at charges 1(a)-(c) above, you admitted that you failed to take sufficient radiographs before commencing root canal treatment at LL3, after providing the root canal treatment, and before preparing the teeth for the seven-unit bridge. As pleaded at charge 3 below, you also admitted that your record keeping was inadequate. The issue for the Committee to decide was whether you had discussed the full risks and benefits of the bridge with Patient 1 on 12 April 2022 and, consequently, whether you had obtained her informed consent. Your case was that you did discuss the full risks and benefits, including the risks of proceeding without radiographs, but failed to record that discussion adequately.

	Your oral evidence was initially that you knew pre-operative radiographs were needed and that you would have liked to take them. When asked why you did not do so, you said Patient 1 had refused. You said that she had been undergoing chemotherapy treatment which had caused a dry mouth, that she found earlier x-rays unpleasant and that she “just plain refused” to have any more taken. You were asked if you explained to her whether pre-operative radiographs were necessary and the risks associated if they were not taken. You said that you did explain this to her. You said you told her that she had a lot of damaged teeth and that you needed to check underneath them to ensure there was no infection, because if a bridge were made over infection, she could experience complications later. In cross-examination, however, you accepted that the clinical records did not record dry mouth, inability to tolerate radiographs, refusal of radiographs, or any attempt to take radiographs. In your oral evidence, you stated for the first time that you had attempted to take radiographs and that the patient refused. You accepted that your witness statement did not say that you attempted to take radiographs. Your witness statement instead described you as having made a clinical judgment not to take further radiographs and made no reference to Patient 1 having categorically refused to have radiographs taken. The Committee considered this to be complex treatment involving your decision to carry out root canal treatment at LL3, an otherwise unrestored healthy tooth, together with a seven-unit bridge. It was not in dispute that pre-operative radiographs were required for the purposes of diagnosis, treatment planning and risk assessment. Without taking pre-operative radiographs, you would have been unable to assess the full risks and benefits of the proposed treatment and would therefore have been unable to discuss these with Patient 1 as part of the consent process. The Committee considered that, where a patient refuses radiographs before complex treatment, or if a dentist attempts to take radiographs and fails, that would be clinically important information relevant to future treatment, consent, and risk management: it is information which is more likely than not to have been recorded in the notes because of the unusual circumstances and because of the clinical significance of proceeding without radiographs. The Committee also noted that radiographs had been taken relatively recently on two separate occasions by another practitioner and that the notes did not record difficulty, distress, dry mouth or refusal on either of those occasions. Having regard to the totality of the evidence, the Committee concluded that the contemporaneous records and your witness

	statement were more reliable than your later inconsistent oral evidence on this point. Accordingly, the Committee determined that the reason you had not taken pre-operative radiographs was because you had made your own clinical judgment not to do so, rather than because Patient 1 had refused to have radiographs taken or because you had attempted to take a radiograph and failed. In those circumstances, a discussion of the full risks and benefits of the proposed treatment would have needed to encompass the significant risks of proceeding without radiographs. Given your inconsistent evidence, the Committee was not satisfied that you had a clear recollection of a specific discussion about the risks of proceeding without radiographs and therefore rejected your oral evidence that such a discussion had taken place. The Committee determined that you had decided of your own motion not to take pre-operative radiographs, which is indicative of a clinical attitude that you did not consider radiographs to be important in this case, and that you had not discussed with Patient 1 the risks of proceeding without them. The Committee therefore found that you failed to discuss the full risks and benefits of the seven-unit bridge. Accordingly, the Committee found this charge proved.
3.	*You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments between 5 February 2018 and 29 April 2022.* **Admitted and found proved.**
4.	*You failed to obtain informed consent from Patient 1 between 12 April 2022 and 29 April 2022 for:*
4.(a)	*root canal treatment at LL3;* **Proved.** See below.
4.(b)	*a 7 unit bridge.* **Proved.** The Committee considered charge 4 in light of its finding at charge 2 above. It accepted the expert evidence that informed consent requires an adequate

	discussion of the proposed treatment, available options, material risks and benefits. The Committee found that the risks of proceeding without sufficient radiographs were not adequately explained. In particular, the Committee was not satisfied that Patient 1 was told, in a way that would allow informed consent, that there might be undetected infection or other pathology and that the proposed treatment carried additional risk because of the absence of current radiographic assessment. In those circumstances, Patient 1 could not have given her informed consent to the root canal treatment at LL3 or to the seven-unit bridge. Accordingly, the Committee found charges 4(a) and (b) proved.
	<u>Patient 2</u>
5.	*You failed to provide an adequate standard of care to Patient 2 between 2 November 2021 and 6 December 2021 in that you:*
5.(a)	*failed to take a pre-operative radiograph of the UR5 and/or the UR4 prior to performing an apicectomy;* **Proved.** Patient 2's case concerned an apicectomy at UR5 and/or UR4. You admitted that you provided an apicectomy when there was an inadequate root canal filling (charge 5(b) below). You admitted inadequate record keeping and failure to obtain informed consent (charges 6 and 7 below). However, you denied that you failed to take a pre-operative radiograph. Your evidence was that you intended to carry out the apicectomy at UR4 and that the record stating UR5 was wrong. You accepted that your note said UR5, but said that was an error, describing it as an error involving one premolar rather than another. In cross-examination, you accepted that the note on 2 November 2021 referred to "apicectomy upper right quadrant", and that this reflected uncertainty as to whether the tooth to be treated was UR4 or UR5. You accepted that no further radiograph was taken between that appointment and the appointment on 6 December 2021 when the apicectomy was performed. You also accepted that without a further radiograph it was very difficult to know which of the two teeth was the source of infection. You nevertheless gave evidence that you could identify the source of infection once the area had been surgically exposed by incising the gum and raising a flap over the

	roots of the teeth, because direct visual inspection could show where pus or infection was travelling. The experts agreed that, if the procedure was clearly to treat UR4, the earlier radiograph might have been sufficient, albeit the radiograph showed that such treatment was inappropriate for that tooth. However, if UR5 remained in contemplation, or if there was uncertainty as to the tooth requiring treatment, a further radiograph was necessary. The Committee concluded that the clinical record referring to the upper right quadrant prior to the appointment shows that, at that stage, you were uncertain whether the source of infection was UR4 or UR5. Therefore, at the point where surgery commenced, there remained uncertainty as to whether UR4 or UR5 was the relevant tooth and indeed you said as much in your oral evidence. In those circumstances, the previous radiograph was not sufficient. A further radiograph should have been taken before performing the apicectomy. Accordingly, the Committee found charge 5(a) proved.
5.(b)	*provided an apicectomy at the UR5 and/or the UR4 when there was an inadequate root canal filling.* **Admitted and found proved.**
6.	*You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments between 20 March 2019 and 11 March 2022.* **Admitted and found proved.**
7.	*You failed to obtain informed consent from Patient 2 for an apicectomy at the UR5 and/or the UR4 between 2 November 2021 and 6 December 2021.* **Admitted and found proved.**
8.(a)-(b)	*You failed to:* *a. maintain adequate processes* *b. ensure adequate processes were followed* *to identify and remove out of date Midazolam in the medical emergency drug box between 1 May 2017 and 6 October 2017.*

	Proved. Mr Lamb was a Dental Professional Adviser for NHS England. He attended your practice on 6 October 2017 following a “whistleblower” allegation of out-of-date drugs. During that visit, he asked to see the medical emergency drug box. In that box, he found in-date Midazolam and also a box of Midazolam which had expired on 1 May 2017, meaning it had remained in the emergency drug box for about five months after expiry. In his report, he described a “very difficult, fraught and long conversation” in which you did not demonstrate “any real concern or insight into the potential risk to patients” and appeared instead to feel “very let down by his staff”. Mr Lamb acknowledged that out-of-date drugs were a concern capable of being rectified by improved processes, and he recorded that he had found no evidence that out-of-date drugs had actually been administered to a patient. Your evidence to the Committee was that processes existed. You said that senior nurses were responsible for checking the drug box and signing off a checklist, and that you believed you had delegated the task appropriately. You relied on practice meetings and instructions to staff. You also referred to a CQC report concerning your other dental practice, which recorded that the medicines checked at that location were in date. You relied upon an emergency drug protocol document dated 2020, which post-dated the events and which referred to weekly checks. You accepted that this document did not itself prove the existence of the same protocol in 2017. You said that the protocol would have been renewed annually and that you could ask staff to search for older documents. You accepted that if weekly checks were supposed to occur, the failure to remove the expired Midazolam would have represented repeated missed opportunities over a period of approximately five months. The Committee considered the fact that in-date Midazolam was also present. That suggested that someone had identified the need for replacement stock. However, the expired box had not been removed. The Committee considered whether this demonstrated a single staff error or an inadequate system. The Committee accepted that there was likely to have been some process in place in 2017. The presence of in-date Midazolam indicated that some stock checking and replacement process had operated. However, the allegation is whether “adequate” processes were maintained, perhaps with new stock being ordered but a failure to ensure that the out-of-date stock was removed. The Committee considered that an adequate process for

	emergency medication must not only identify expired medication but also ensure its removal from the emergency drug box. Here, the expired Midazolam had remained in the emergency drug box for approximately five months. If weekly checks were required, this represented at least twenty missed opportunities to identify and remove it. The Committee considered that this could not properly be characterised as a single isolated oversight within an otherwise adequate system. The Committee also considered Mr Lamb's concern that the process needed to be improved, suggesting that it was not adequate at that time. It regarded his evidence as important contemporaneous evidence. It further noted that your response at the time, which Mr Lamb considered to show limited insight into the risk, suggested that there had not been a robust system in place. The Committee was satisfied that you failed to maintain adequate processes to identify and remove out-of-date Midazolam and therefore also failed to ensure that such processes were followed. Accordingly, the Committee found charges 8(a)-(b) proved.
9.	*Your conduct at allegation 8 put patient safety at risk.* **Proved.** The Committee accepted the expert evidence that the presence of out-of-date medication in an emergency drug box creates a material risk. In an emergency, medication may be selected and administered under time pressure. A practitioner may reasonably assume that medication in the emergency drug box is in date: the normal secondary safeguard of checking the expiry date of a medication prior to administering it is less likely to be followed in an emergency situation, where time is of the essence. The Committee was satisfied that the presence of expired Midazolam in the emergency drug box for approximately five months created a risk that it might be accidently administered during an emergency and, because it had expired, it may not have been effective, thereby putting patients at risk. Accordingly, the Committee therefore found charge 9 proved.
10.	*You caused a letter, dated 9 May 2022, to be sent to patients, in which you stated that:*
10.(a)	*Colleague A had "stolen data" from the practice;* **Admitted and found proved.**

10.(b)	*Colleague A had been dismissed from the practice "the moment he stole patient details".* **Admitted and found proved.**
11.	*The statements at allegation 10 a and/or b above were incorrect.* **Admitted and found proved.**
12.	*For a period of time up to and including at least 9 May 2023, you have stated the following on your Practice website:*
12.(a)	*"New 3D very low Dose Xray Machine. We are the only practice in Suffolk to have invested in this essential state of art technology";* **Admitted and found proved.**
12.(b)	*"Paul Brown is one of the UK's most experienced implant dentists having placed many of hundreds of implants and their fixtures during his career so far".* **Admitted and found proved.**
13.	*The statements at allegation 12 a and/or b above were incorrect.* **Admitted and found proved.**
14.	*Your conduct at allegations 10 and/or 12 above was:*
14.(a)	*misleading;* **Admitted and found proved.**
14.(b)	*dishonest.* **Not proved in relation to charge 10(a).** **Proved in relation to charge 10(b).** **Not proved in relation to charge 12(a)-(b).** <u>Charge 10</u> Colleague A had worked as an associate dentist at the practice. On 3 May 2022, he emailed you and your wife (the co-owner of the practice) to tender his resignation. In that email, he stated that he was establishing his own

practice. He offered to work a notice period, but that offer was not accepted. He did not return to the practice after sending the resignation email.

On or around 10 May 2022, Colleague A became aware that a letter dated 9 May 2022 had been sent to patients of the practice. This letter stated that a previous employee had “stolen data from the dental practice” before leaving and setting up his own practice. It named Colleague A, identified his new practice, and stated that his employment had ceased “the moment he stole patient details”.

The letter also referred to the matter being reported to the police and repeated the allegation of “the theft of your confidential data”. It suggested that Colleague A had focused on his own needs rather than the interests of patients.

You admitted that the letter was sent and that the statements at charge 10 were made. You also admitted that those statements were incorrect and misleading.

You referred to what you thought were suspicious emails and also to a spreadsheet with patient details that had been discovered on the practice computer and that you had not authorised its creation. You said that you were alerted to it by staff. Your case was that you genuinely believed that the spreadsheet was evidence that Colleague A had taken or misused patient data.

You also relied on the fact that you had instructed solicitors and on their advice reported the matter to the police and the Information Commissioner’s Office. You gave evidence that the ICO report was made on 10 June 2022.

Colleague A’s evidence was that the spreadsheet had been created by a member of the reception team so that patients undergoing active treatment could be contacted to complete treatment before his departure. He said that the spreadsheet remained on the practice computer and was not copied onto any personal device.

The Committee considered that, whatever the truth of the spreadsheet’s origin and purpose, the critical questions for dishonesty were your actual belief as to the “stolen data” allegation and your actual knowledge as to whether Colleague A had been dismissed. Importantly, as you now accept, there is no evidence that Colleague A had stolen or otherwise removed data from the practice. Neither had he been dismissed from the practice in relation to this.

	There was also significant dispute before the Committee as to whether Colleague A had in fact signed a contract with your practice. When provided with a document from the practice records purporting to bear his signature, he was adamant that he had never signed any document and expressed concern that the document was false. He referred to the handwritten date being in your handwriting against not only your signature but his. He also referred to the handwritten date of Friday "1 1 21" as being New Years Day, stating that he would not have signed a contract on a bank holiday and he also suggested that you might have been out of the country on holiday during that period. Although much was made of the authenticity or otherwise of the signed contract, nothing turned on it in the Committee's view. The Committee does not have the forensic ability to investigate and determine the authenticity of the signature and makes no finding in relation to it. Whether or not Colleague A had previously signed a contract did not directly go to any of the charges which the Committee is to decide, albeit it was potentially relevant to the wider context you wished to put forward as part of your defence. Nothing turned on that wider context, as the Committee in any event accepted that you genuinely believed that Colleague A had "stolen data". The relationship between you and Colleague A had broken down. Colleague A had resigned and was establishing a new practice (whether or not this was in breach of any signed contract). A spreadsheet containing patient information had been found on the practice computer. You believed that the spreadsheet was connected with Colleague A's departure and that patient data had been taken or misused: you believed that he was trying to use that data to contact your patients and get them to join his new practice. The Committee considered the evidence that you sought legal advice and reported the matter externally to the police and ICO. These acts were relevant in the Committee's view as to whether you genuinely believed that patient data had been stolen or misused. The Committee determined that you genuinely believed at the time that Colleague A had stolen or misused the data in question and that your corresponding statement in your letter dated 9 May 2022 therefore reflected what you believed to be the case at the time. The Committee considered the word "stolen" serious, intemperate and damaging. It conveyed criminality. The Committee considered the letter inappropriate and misleading. However, the reasonableness or otherwise of your defensive or emotionally charged belief does not go to the question of dishonesty for the purposes of these proceedings: what is relevant is what

	you genuinely believed at the time. Applying the dishonesty test set out in *Ivey v Genting Casinos (UK) Ltd, t/a Crockfords* [2017] UKSC 67, the Committee was not satisfied that ordinary decent people, knowing your actual belief at the time, would regard that particular statement as dishonest. The Committee therefore found dishonesty not proved in relation to charge 10(a). As to charge 10(b), the incorrect statement that Colleague A had been dismissed from the practice "the moment he stole patient details", the Committee found this materially different from your claim that data had been stolen. Whilst Colleague A was not technically an employee (he was a self-employed associate), the Committee accepted that the distinction was purely semantical for the purposes of the letter to the patients, where terminating his contract might more naturally be expressed in lay terms as "dismissing" him. The issue for the Committee was whether you genuinely believed the point being conveyed to be true. You knew that Colleague A had resigned on 3 May 2022. You knew that he had not been dismissed (or his contract otherwise terminated) "the moment" patient details were allegedly stolen. You were the person best placed to know the circumstances in which he left the practice. The Committee considered your evidence that the wording came from your solicitors. However, the solicitor's knowledge came from information provided by you and others at the practice. You read the letter, carefully considered its wording and made amendments. You removed language you considered inappropriate, including language suggesting that setting up his practice was "unlawful". You had therefore applied your mind to the letter. The statement that Colleague A had been dismissed "the moment" he stole patient details was not a minor drafting error. It was a serious allegation. It gave patients the impression that the practice had discovered wrongdoing and immediately acted responsibly by dismissing him. The Committee rejected your explanation that the true position was simply not in your mind. Colleague A's resignation was central to the events. His departure had upset you. The Committee found that you knew he had resigned and had not been dismissed in the way conveyed.

	The Committee was satisfied that ordinary decent people would regard it as dishonest to tell patients that a professional colleague had been dismissed when you knew that he had earlier resigned and had not been "dismissed". Accordingly, the Committee found dishonesty proved in relation to charge 10(b). <u>Charge 12</u> The practice website contained two statements relevant to charge 12. The first stated: "New 3D very low Dose Xray Machine. We are the only practice in Suffolk to have invested in this essential state of art technology." The second stated: "Paul Brown is one of the UK's most experienced implant dentists having placed many hundreds of implants and their fixtures during his career so far." You admitted that those statements appeared on the practice website, that they were incorrect, and that they were misleading. Your case was that the 3D very low Dose Xray Machine statement had been true when first published but became out of date as other practices in Suffolk began introducing such technology over the years, and that the implant-dentist statement reflected your genuine belief at the time but ought to have been phrased more cautiously. You deny that the website statements were dishonest. In relation to the 3D very low Dose Xray Machine statement, the Committee accepted that the statement may have been true when first published. It became untrue over time. You ought to have reviewed and corrected it. The statement was public-facing and potentially attractive to patients. However, the Committee was not satisfied that the GDC had proved dishonesty. The evidence supported the conclusion that the statement had been left on the website through neglect, omission or disorganisation. The Committee was not satisfied that you deliberately left the statement there to deceive patients. It is more likely in the Committee's view that you simply failed to update your website. In relation to the statement that you were one of the UK's most experienced implant dentists, the Committee considered the wording exaggerated and self-promotional. It was misleading. However, the Committee was not satisfied that it was dishonest. It considered that the statement reflected an inflated view of your own experience rather than proved dishonesty. You genuinely regarded yourself in those relatively subjective terms. There was

	not a conscious intention to mislead your patients by describing your skill and experience in this way. The Committee therefore found dishonesty not proved in relation to the website statements under charge 12.
15.	*You failed to treat a colleague with respect, between March 2021 and December 2022, in that:*
15.(a)	*you insisted that Colleague B should use an English name,* [REDACTED] *rather than her real name,* [REDACTED]*, whilst at work:* **Admitted and found proved.**
15.(b)	*you insisted that other members of staff should refer to Colleague B as* [REDACTED] *rather than her real name,* [REDACTED]*;* **Admitted and found proved.**
15.(c)	*you addressed Colleague B in emails as* [REDACTED] *despite her signing off her emails to you as* [REDACTED]*;* **Admitted and found proved.**
15.(d)	*you informed Colleague B that patients would not respect her if she used her real name;* **Admitted and found proved.**
15.(e)	*you told Colleague B when she had days with lots of patients that it was because she had changed her name to* [REDACTED]. **Admitted and found proved.**
16.	*You failed to treat a colleague with respect in that, between April 2021 and March 2022, you repeatedly made comments about Colleague C's size:*
16.(a)	*in front of colleagues;* **Admitted and found proved.**
16.(b)	*in front of patients.* **Proved.**

	Whilst you admitted that you had made comments about Colleague C's size in front of colleagues, you denied that you had done so in front of patients (plural). Colleague C's evidence was that comments about his size were frequent and were used as jokes, including in front of patients. Examples included comments to the effect that he was a very big lad, loved pies, or loved beer. Colleague A also gave evidence that you commented on Colleague C's weight and blamed him for wearing a hole in the floor where his chair was. The Committee also considered your own evidence. You admitted making comments about Colleague C's size or build in front of colleagues, as set out at charge 16(a) above. In cross-examination, you accepted that you had made at least one comment about his build in front of a patient who was a friend. You also accepted the comment about the hole in the floor and explained it by reference to Colleague C's size and weight. The Committee recognised that one patient was not enough to prove this charge because the charge alleges patients in the plural. However, the Committee considered that your own admission that such a comment had occurred in front of one patient made it more likely that Colleague C's evidence of comments being made in front of patients was correct. The Committee found Colleague C credible and consistent on this issue. The comments were habitual and normalised in the practice, as demonstrated by the evidence of Colleague A. In all the circumstances, the Committee considered it more likely than not that the comments were not confined to colleagues or to one patient only. Accordingly, the Committee found charge 16(b) proved.
17.	*You failed to treat colleagues with respect in that,*
17.(a)	*at a team meeting in or around September 2021, in front of colleagues, you shouted at Colleague C and called him stupid, or words to that effect;* **Proved.** See below.
17.(b)	*on or around 4 May 2021, you shouted at one or more colleagues in a meeting regarding a face mask having been discarded in the wrong bin;* **Proved.**

	See below.
17.(c)	*on or around 11 May 2021, you shouted at one or more colleagues in a meeting regarding rescheduling of patients' appointments;* **Proved.** See below.
17.(d)	*on or around 11 May 2021, on another occasion, you shouted at Colleague D regarding her rescheduling of a patients'* [sic] *appointment;* **Proved.** You denied charges 17(a) to 17(d), principally on the basis that you raised your voice but did not shout. You admitted charge 17(e), while disputing the word "bloody". The Committee considered the distinction between a raised voice and shouting. It considered the context, the surrounding events, the witnesses' accounts, and the effect on those present. In relation to charge 17(a), the Committee accepted Colleague C's evidence that, at a team meeting, you shouted at him and called him stupid or words to that effect. The Committee considered this consistent with your admitted later use of "stupid" towards Colleague C in March 2022. It rejected the suggestion that this was merely a firm raised voice, taking into account Colleague C's evidence that you were very aggressive and dismissive, and that your face turned red during this exchange. In relation to charge 17(b), Colleagues C and D both gave evidence about this incident. They described you as angry and aggressive, holding the face mask, pointing at members of staff and asking words to the effect of "was it you?" whilst cutting people off as they tried to respond. The Committee accepted that disposal of clinical waste was a serious matter and that you were entitled to address it. However, the issue was the manner in which you did so. The Committee found that your conduct went beyond a raised voice and amounted to shouting. In relation to charges 17(c) and 17(d), the Committee considered Colleague D's evidence about the rescheduled appointment. The Committee accepted that there was a legitimate issue about appointment management and patient care. However, again the issue was your manner.

	Colleague D's contemporaneous resignation email referred to "raising your voice" rather than shouting. The Committee took that into account. It also took into account her concession that, with the passage of time, it may have been a very raised voice rather than shouting in a technical sense. However, the Committee considered her evidence as a whole. She described the conduct as intimidating and patronising. She resigned on the same day, stating in her resignation letter: "…We are all adults and in my opinion, raising your voice, swearing and pointing fingers at people's faces while cutting them off without allowing the person to finish a sentence constitutes to work place bullying…"[sic]. In email correspondence to the GDC on 25 August 2023 as part of its investigation into your fitness to practise, she stated: "…On two separate occasions (04/05/21 and 11/05/21) Paul Brown called everyone who was working on the day into his surgery and closed the door and started shouting at us, making eye contact with each one of us whilst literally pointing fingers and swearing as well as cutting people off when trying to speak to him. At the time I felt this was disrespectful and unprofessional and therefore I sent my resignation". Colleague D's account was supported by Colleague C's evidence that Colleague D came out of the meeting crying. You accepted that the conversation became heated, that you interrupted her, and that you raised your voice. The Committee also had regard to the terms of Mr Lamb's report on the occasion of his visit, which sets out that you went from being friendly and chatty to appearing to becoming "very confrontational" when the expired medicines were brought to your attention. He also said that you "often spoke over" him and he tried to calm you down but you "refused to". The Committee considered that this was suggestive of a pattern of inappropriate behaviour in adverse circumstances. The Committee determined, on the balance of probabilities, that you had not raised your voice in a neutral way to be heard. It was more likely to be a loss of temper or aggressive expression of frustration. The Committee therefore found that the GDC had proved shouting in the sense alleged. Accordingly, the Committee found charges 17(a)-(d) proved.
17.(e)	*on or around 10 March 2022, you called Colleague C "bloody stupid", or words to that effect, when he insisted that a dental handpiece should be sterilized.* **Admitted and found proved.**

	Charge 17(e) was admitted but not the use of the word "bloody". The Committee considered that whether the word "bloody" was used was not determinative because the charge pleads "or words to that effect". You accepted calling Colleague C stupid.
18.	*In or around May 2022, you failed to treat a colleague with respect in that, in front of a patient:*
18.(a)	*you insisted that Colleague C should put a belt on that was too small for him;* **Proved.** See below.
18.(b)	*you told Colleague C "I'm going to give you six months for this to fit", or words to that effect.* **Proved.** You accepted that the belt incident occurred and that it was inappropriate. You denied that it occurred in front of a patient. The Committee considered Colleague C's oral evidence. He gave a detailed account. He said you told him to bring the patient in, that he did so, that you went upstairs, returned with a belt, told him to put it on, and made the six-month comment. He said the incident occurred in front of the patient and that he remembered it clearly. In his witness statement, he stated: "…This entire exchange was in front of the patient, the patient seemed taken back be these comments but did not say anything. It was very demeaning, and felt as if he had only gotten the patient into the treatment room to make this demonstration in front of them. I made the decision to leave the Practices on the same day, due to the bullying I received from the Registrant about my weight. Following that at the end of the working day I said goodbye, stating in an email shortly after I was leaving with immediate effect…" You said that the incident occurred elsewhere, not in front of a patient. However, the Committee found Colleague C's evidence on this point detailed, consistent and credible and noted his resignation email after this incident, in which he resigned with immediate effect. It was also consistent with the Committee's earlier finding that comments about his size were made in front of patients. The Committee therefore accepted Colleague C's evidence that the incident occurred in front of a patient and that this was demeaning and disrespectful.

	Accordingly, the Committee found charge 18(a)-(b) proved.
19.	*In or around 2021 you made inappropriate comments to colleagues and/or patients, in that you:*
19.(a)	*stated to one or more colleagues that they should refer to Colleague E as* [REDACTED] *as "no one would have trust in a* [REDACTED]*" or words to that effect;* **Not proved.** The evidence in support of this allegation, which you deny, came from the account of Colleague C. The Committee also considered the email sent 31 May 2021 (see charge 20 below) concerning Colleague B, which referred to Colleague E and to perceptions of names. The relevant part of the email stated: "…[REDACTED] is very fortunate that his surname is synonymous with hard work, ability and friendliness. His forename is shared with the [REDACTED] - the most trusted position at the leadership of our country…". The Committee accepted that you had made inappropriate comments about names and patient perceptions. However, the contemporaneous email concerning Colleague E's name did not support the specific allegation recounted by Colleague C that you said "no one would have trust in a [REDACTED]". On the contrary, the email referred to Colleague E in positive terms and did not show the same discriminatory attitude towards Colleague E's surname as was directed towards Colleague B's forename. The Committee noted that the Practice Manager at the time was said by Colleague C to be present when this comment was made, but when she gave evidence she said that she had not heard this. There was therefore a lack of corroborative evidence in support of Colleague C's account in this regard. The Committee was not satisfied that the GDC had proved the specific words alleged or words to that effect. Accordingly, the Committee found this charge not proved.
19.(b)	*stated to one or more patients that an individual had walked out to a boxing match to "Nigger black music" or words to that effect;* **Proved.**

	Charge 19(b) alleged that in or around 2021 you stated to one or more patients that an individual had walked out to a boxing match to “Nigger black music”, or words to that effect. You denied the charge as pleaded. You accepted inappropriate use of the N-word in the context of explaining to colleagues what the “N” in the band name “NWA” stood for, with the remaining two letters standing for “With Attitude”. However, you denied making the alleged comment in front of patients. The Committee considered Colleague C’s written and oral evidence. His evidence was that you discussed your son’s boxing match with patients during the day and used the phrase alleged. He said that he could clearly remember you saying this to multiple patients throughout the day and he remembered one patient gasping in reaction. Colleague C said he remembered this comment quite clearly as he told his father and friends when he got home. In oral evidence, Colleague C rejected the suggestion that he had misunderstood a reference to the band NWA. He accepted that he knew the band but maintained that this was not what had been said by you. He also said that he did not think the comment was made with malice, but that it was clearly inappropriate and said in front of patients. The Committee found Colleague C’s evidence credible on this point. The Committee also considered that Colleague C’s evidence, that he challenged you between patients because he was shocked, was plausible. The Committee considered your evidence to be less reliable. Your account of the context in which the N-word was used was less persuasive than Colleague C’s evidence. Your reference to NWA appeared to evolve as your evidence developed. In your statement, you said that your son’s opponent had entered the ring to a song by a band called “Niggers With Attitude”. You then said “I am now aware that the band refers to itself as “NWA”. In other words, at the time of making this comment you did not know that “NWA” was the way in which the band is actually referred to. Accordingly, you could not have been explaining to Colleague C what the “N” stood for in “NWA”. Indeed, you go so far as to say in your statement, that at the time, you referenced the full name of the group. The Committee was satisfied, on the balance of probabilities, that the comment was made to one or more patients as alleged and that it was not in reference to explaining what the “N” stood for in NWA but was used as a descriptor for a genre of music.

	Accordingly, the Committee found charge 19(b) proved.
19.(c)	*stated to one or more colleagues "Do you know who make the best practice owners? Poofs" or words to that effect;* **Admitted and found proved.**
19.(d)	*stated to Colleague A that Patient 3 was a "coffin dodger" or words to that effect.* **Not proved.** The only evidence in support of this charge, which you deny, was Colleague A's evidence. The Committee considered the absence of corroborating evidence and the fact that this was an isolated alleged comment. Whilst the alleged comment was not inherently implausible in light of some of the other language found proved or admitted, plausibility is not sufficient to prove a charge. The Committee was not satisfied that the GDC had proved, on the balance of probabilities, that the comment was made given the conflict of evidence between you and Colleague A and the lack of any corroborating evidence. Accordingly, this charge was found not proved.
20.	*Your conduct at allegations 15 a - e and/or 19 a and/or b above was (a) offensive; and/or (b) racially motivated.* **20(a) admitted and found proved in relation to charge 15(a)-(e)** **20(b) found proved in relation to charges 15(a)-(e)** **20(a) found proved in relation to 19(b)** **20(b) found not proved in relation to 19(b)** <u>Charge 15</u> You admit that your conduct at charge 15 was offensive. Colleague B's evidence concerned your insistence that she use the name [REDACTED] rather than her real name, [REDACTED], while at work. You admitted the factual allegations at charge 15 and admitted that your conduct was offensive. You denied racial motivation.

Colleague B's evidence was that you told her patients would not respect her if she used a foreign name. She said you insisted staff call her [REDACTED], corrected staff when they used her real name, addressed her as [REDACTED] in emails even when she signed off as [REDACTED], and told her on busy days that she had patients because she had changed her name to [REDACTED].

The Committee considered the email sent by you and your wife to Colleague B on 31 May 2021. The email stated:

> "…It's very important you listen to what Paul says:
>
> Please remove [REDACTED] name tag from your uniform - it must say [REDACTED]. Staff must also refer to you as [REDACTED] at all times.
>
> Unfortunately if not, some patients in time will try to undermine you . This is unfortunately the British way - horrible but true, it stems back from colonial times when British people tried to rule people of other nations - the Irish, coloured people, Arabs and Blacks - bad behaviour which is still embedded in the British character.
>
> Thankfully both Indian and Chinese practitioners are generally very well respected because they have had enough time since the 1960s to very positively impact the nations attitude by working hard and consistently with kindness and empathy.
> [REDACTED] is very fortunate that his surname is synonymous with hard work, ability and friendliness. His forename is shared with the [REDACTED] - the most trusted position at the leadership of our country.
>
> You are doing very well - and you have the potential to do great things at our practice.
> But it's important step up from Scotland as private patients in Suffolk can be very discerning.
> Paul and […] will give you every support we can so that your associate ship is successful…"

In your oral evidence, you explained that you thought you were protecting Colleague B. You said that there was tension in Suffolk regarding foreigners and asylum seekers, that Colleague B came from Iraq and was of Kurdish descent, and that her name was unusual for an English person. You referred to another dentist who anglicised his forename. You said that you thought it was in her interests to anglicise her name.

The Committee considered whether your conduct at charge 15 was racially motivated, which you formally denied albeit with a later reflective concession in your oral evidence that your conduct amounted to discrimination because you had treated her differently.

In relation to racial motivation, the Committee considered the test laid down in *Robert Lambert-Simpson v HCPC* [2023] EWHC 481(Admin), namely whether:

a. the act in question had a purpose behind it which, at least in significant part, was referable to race; and

b. the act was done in a way showing hostility or a discriminatory attitude to the relevant racial group.

The Committee reminded itself that racial motivation does not require proof of overt hatred. A discriminatory attitude may be sufficient. Conversely, a comment may be racially offensive without necessarily being racially motivated.

The Committee accepted that your stated intention was to protect Colleague B from prejudice and to help her succeed professionally. It accepted that you did not regard yourself as acting out of hostility.

However, the Committee found that the conduct was plainly referable to race. In your own oral evidence, you said that Colleague B came from Iraq, was of Kurdish descent, and that there was tension in Suffolk regarding foreigners and asylum seekers. You said that her name was unusual for an English person and that you thought it would be in her interests to anglicise it.

The Committee found that the first limb of the test was satisfied. The purpose of the conduct was, at least in significant part, referable to race. It was not simply about convenience, pronunciation or administration. It was about how patients would respond to Colleague B's name and ethnic background.

The Committee then considered whether the conduct showed hostility or a discriminatory attitude to the relevant racial group. The Committee did not find that you were motivated by any form of hatred. There was no evidence of hatred or ill feeling towards Colleague B. From your perspective you were being supportive and protective of her.

	However, there was clear evidence of a discriminatory attitude. You treated Colleague B differently because of her name, ethnicity and perceived background. You imposed an English name on her because of your assumptions about how patients would respond to her real name. Your oral evidence included the important admission that, in retrospect, you knew you had treated her differently from everybody else and that this was discrimination. Accordingly, the Committee found "offensive" and "racially motivated" were proved in relation to charge 15. <u>Charge 19(b)</u> You admit that your conduct (in so far as admitted) at charge 19(b) was offensive. The Committee found it also to be offensive in relation to your use of the term in front of patients. It was deeply offensive and shocking. It is an offensive racial slur which should never be used at all and certainly not in a clinical or professional environment. The Committee gave very careful consideration to whether your use of this term was also racially motivated. Whilst the term is racially offensive, the Committee reminded itself that racial offensiveness and racial motivation are not the same. The Committee had regard to context. The comment was made in the context of describing a genre of music that was being played during a walk-out at a boxing match. Colleague C himself said he did not think it was said with malice. The Committee was satisfied that the act had a purpose which, at least in significant part, was referable to race, in that you admitted you used the "N" word. However, the Committee was not satisfied that it was done in a way showing hostility or a discriminatory attitude to the relevant racial group. The word was used casually and conversationally by you as a descriptor for a genre of music. This was deeply offensive and shocking. The Committee was not however satisfied from the evidence that your intention was to be offensive, hostile or discriminatory. It was an exceptionally poor and ill-judged use of language but there was no evidence that it was said with malice or hostility. There was also no evidence that you had used the term in any context other than this specific boxing match. Accordingly, the Committee found "offensive" proved in relation to charge 19(b) but not "racially motivated".
21.	*Your conduct at allegation 19 c was (a) offensive; and/or (b) homophobic.* **21(a) admitted and found proved.**

21(b) not proved.

You admitted that your comment was offensive but denied that it was homophobic.

The Committee considered whether the comment was also homophobic.

The Committee accepted the Legal Adviser's advice that "homophobic" should be considered by reference to whether the conduct involved or related to fear or hatred of gay people.

The Committee distinguished between conduct which is inappropriate or based on stereotypes, and conduct which amounts to homophobia.

You explained that the comment was made in the context of discussing the challenges of balancing family responsibilities with running a dental practice. You said that you were referring to gay practice owners whom you knew and regarded as highly successful and committed, and who treated their practices as their "family".

You accepted that your use of language was "completely inappropriate, offensive and disrespectful". You said that you should never have expressed yourself in that way and that you regretted having said it and any upset caused.

In relation to the allegation of homophobia, your position was that, although the term was offensive, your intention was to be positive and complimentary to homosexual individuals, not malicious or homophobic. You denied discriminatory intent and said you had reflected on how to communicate more respectfully.

The Committee considered the comment crude, offensive and inappropriate. The Committee considered that your stated intention to be complimentary did not remove the offensiveness of the term "poofs" or the stereotypical assumption which underpinned your comment.

However, the Committee was not satisfied that the GDC had proved that the comment involved or related to fear or hatred of gay people. There was no evidence of any fear, hatred or hostility towards gay people. The term "poofs" can be pejorative depending on the context in which it is used but the Committee accepted your evidence that the term was simply part of your own inappropriate vocabulary and was not intended to be disrespectful. The Committee therefore found homophobia not proved.

	Accordingly, the Committee found that your conduct at charge 19(c) was "offensive" but not "homophobic".
22.	*Between 27 September 2021 and 24 May 2022, you submitted or allowed to be submitted claims to the NHS in your performer number for dental treatment carried out by Colleague F.* **Admitted and found proved.**
23.	*Between 27 September 2021 and 24 May 2022, you caused and/or permitted Colleague F to treat NHS patients whilst he did not have an NHS performer number and was not on the NHS performers list.* **Admitted and found proved.**
24.	*Your conduct in respect of 22 and/or 23 above was dishonest in that you intended to give the NHS the impression that you had carried out NHS funded dental treatment when you had not.* **Proved.** Colleague F was a newly qualified dentist who had qualified overseas. He did not have an NHS performer number. He was fully registered with the GDC and would therefore have been able to undertake private work. However, in order to carry out NHS work he would have needed to have a performer number, as set out in the uncontested witness statement dated 16 January 2025 of Ms A. Stride of the Professional Standards Team, East Region, at NHS England, which states: "13. Dentists who would like to carry out treatment and services under an NHS contract must be registered on the NHS England National Performers List, which was introduced on 1st April 2013. Allowing someone else to complete treatment under your performers number would place you in breach of your NHS contract. There is also an element of claiming NHS monies for work done by someone else under your number, this could be considered fraud. 14. The National Health Service (Performers Lists) (England) Regulations 2013 Regulation 3. Performers Lists (1) The Board is to prepare, maintain and publish, in accordance with this Part as modified or supplemented by the relevant part - (b) a dental performers list Regulation 31 Dental performers list

	(1) A dental practitioner may not perform any primary dental services unless that dental practitioner is included in the dental performers list." You admitted that you caused or permitted Colleague F to treat NHS patients while he did not have an NHS performer number and was not on the NHS performers list. You admitted that between 27 September 2021 and 24 May 2022 you submitted, or allowed to be submitted, NHS claims under your own performer number for treatment carried out by Colleague F. You admitted that the effect of this was misleading as it suggested to the NHS that you had carried out the treatment when you had not. You denied that you had acted dishonesty. You said that the relevant period was difficult. You referred to post-COVID pressures, patient demand, other local practices closing, delays in obtaining performer numbers, and your wish to maintain NHS access to care, particularly for children. The Committee accepted that there were genuine pressures on the practice. It accepted that the process for obtaining a performer number may have been time consuming, as it necessarily involved multiple checks on the applicant's suitability to work with NHS patients. The Committee also accepted that part of your motivation may have been to ensure that NHS patients continued to receive care. However, the Committee found that you were an experienced dentist and practice owner of some 25 years. You knew that a dentist needed an NHS performer number and had to be on the performers list in order to provide NHS treatment in their own right. You knew that Colleague F did not have a performer number and therefore was not permitted to provide NHS treatment. Colleague F's evidence was that he understood he could treat NHS patients under your supervision. The Committee accepted that Colleague F was inexperienced and that he may have believed he was able to act as he did. However, that does not go to your state of mind in relation to the question of dishonesty. The Committee accepted that, if the NHS had requested the records, it might have been possible to identify who had carried out the treatment. However, the claims submitted to the NHS were submitted under your performer number. The NHS was not reviewing the clinical notes when processing those claims. It would have no reason to call for the records. The impression given by the claims was that you had carried out the NHS-funded

	treatment rather than Colleague F, who was not permitted by the NHS to do so. The Committee accepted your explanation that claims would have been submitted by the reception staff. However, whatever the mechanism, you allowed the claims for NHS work carried out by Colleague F to be submitted under your performer number and you must have instructed your staff to do it in this way. At all times, you were responsible for the arrangement. The Committee noted that the conduct continued over a period of seven months. It was not a single error. You were aware that Colleague F was treating NHS patients and that NHS claims were being made under your performer number. You knew that the NHS would not be aware that the treatment had been carried out by Colleague F rather than by you. The Committee found that you intended the NHS to process those claims under your performer number. You knew that Colleague F had carried out the NHS treatment. You knew that he did not have an NHS performer number. Accordingly, whatever the motive, you set out to deceive the NHS into believing that you had carried out this work. The Committee was satisfied that ordinary decent people would regard that conduct as dishonest. The performer-number system exists so that the NHS can identify who is providing NHS-funded treatment and ensure that the person is entitled and qualified to do so. Submitting claims under your performer number for treatment carried out by a dentist who is not on the performers list undermined that system. Accordingly, the Committee found this charge proved.
25.	*Alternatively, your actions in 22 and/or 23 above were misleading in that the NHS were misled into thinking you had carried out dental treatment funded by the NHS when you had not.* **Admitted but fell away in light of charge 24 above being found proved.** Charge 25 was pleaded in the alternative to charge 24 and confined the scope of the conduct to being misleading. As the Committee found that such conduct was also dishonest, charge 25 falls away.

We move to Stage Two.

Stage two 22 June 2026

21. At this stage of the proceedings, the Committee shall decide whether the facts found proved amount to misconduct; whether your fitness to practise is currently impaired by reason of that misconduct; and, if so, what action, if any, to take in respect of your registration.

22. You did not give evidence to the Committee at this stage but provided a written reflective statement. The Committee had careful regard to that statement and to all the other material placed before it, including information relating to the interim conditions and workplace supervision to which you have been subject over the past three years pending this hearing, along with your Continuing Professional Development (CPD) record and evidence of changes you have introduced to your practice. The Committee also received a large number of testimonials in support of you, with two of those character witnesses (a former colleague and a long standing patient) supplementing their testimonials in oral evidence to the Committee.

23. The Committee also received observations from both experts instructed in this case, in which they commented on your CPD and remediation in relation to the clinical failings which had been found proved.

24. In terms of your fitness to practise history, the Committee was provided with a copy of a published warning which had been issued to you by the Case Examiners on 20 June 2019 for a period of six months and which read:

    The Case Examiners formally warn the Registrant that failure to:

    - obtain and record consent can have serious effects on the individual patient, and on the wider trust and public confidence in the profession. He must ensure that a patient's full, informed consent is obtained prior to carrying out any procedures, and this should be fully documented inclusive of recording discussions about their associated risks and benefits, and costs, and making sure that these have been understood by the patient (or that person's representative).

    - maintain accurate and detailed records can impact upon ongoing patient care. Clinical records must be sufficiently detailed so as to allow future audit or review, to understand any and all clinical considerations, justifications and potential diagnostic conclusions reached as well as the actions he has carried out and the information discussed with the patient.

    - undertake a systematic and appropriate assessment of a patient's presenting dental condition may result in deficient treatment planning and inadequate care. It is necessary to ensure that sufficient assessments, such as occlusal assessments and extra, and intra, oral examinations, are carried out, and suitably recorded, to assist with treatment planning.

- provide treatment plans to the patient along with the costs of treatment can prevent the patient from considering all of the requisite information. It is necessary to ensure that patients are always provided with full details about all of their treatment, including costs and treatment plans, to ensure they can completely understand their on-going, or proposed, dental care and aftercare provisions.

- treat patients with an appropriate level of dignity and respect may result in patients complaining about the way they have been managed. It is therefore necessary to ensure that your communications with patients are professional, fair, accurate and take into account the applicable provisions within the General Dental Council's 'Standards for the Dental Team' (September 2013) publication, namely Standard 1.2 (You must treat every patient with dignity and respect at all times) and Standard 2.3 (You must give patients the information they need, in a way they can understand, so that they can make informed decisions).

- put patients' interests before your own or those of any colleague or a business, may result in a potential breach of provisions within Standard 1.7, 'Standards for the Dental Team', inclusive, although dependent on the circumstances, of those within the guidance stated in paragraph 1.7.8. It is consequently necessary that you ensure that due recognition is given to, and adherence is maintained with, such professional regulatory requirements.

25. The Committee had regard to the submissions of both counsel.

26. On behalf of the GDC, Ms Tahta submitted that the facts found proved amount to misconduct. She referred to repeated and serious clinical failings, including failings similar to matters about which you had previously been warned by the Case Examiners; failures in practice governance which put patient safety at risk; dishonest conduct; racially motivated conduct; racially offensive conduct; and other inappropriate conduct towards colleagues.

27. Ms Tahta submitted that your fitness to practise is currently impaired by reason of misconduct, on both public protection and public interest grounds. She submitted that, although you have undertaken some remedial work, your insight remains limited and developing. She submitted that you had denied the most serious matters found proved, including dishonesty and racial motivation, and that your reflections and CPD were too recent and insufficiently embedded to demonstrate that there was no ongoing risk of repetition.

28. Ms Tahta submitted that the appropriate and proportionate outcome in this case is a 12-month suspension with a review. By reference to the recent authority of *Grzelczak v General Dental Council* [2026] EWHC 890 (Admin), she submitted that, although close to

the threshold for erasure, your misconduct is not so irremediable as to make erasure the appropriate outcome. She submitted that a substantial period of suspension is necessary to mark the seriousness of your misconduct, to protect the public, maintain public confidence in the profession, and allow you time to demonstrate genuine and embedded remediation.

29. On your behalf, Mr Haycroft accepted that the facts found proved amount to misconduct and that your fitness to practise is impaired by reason of that misconduct, although only on public interest grounds. He submitted that this was not a case requiring a lengthy suspension. He submitted that you had demonstrated insight, remorse, engagement and remediation, including through your admissions, your cooperation with the proceedings, your reflective work, your CPD, and the remedial work you had undertaken as part of the order for interim conditional registration to which you have been subject for the past three years.

30. Mr Haycroft referred the Committee to the testimonials provided on your behalf. He submitted that these showed you to be a competent, caring, hard-working and valued dentist, and that your misconduct did not reflect an ingrained dishonest character or an irremediable attitudinal problem. He submitted that a short period of suspension with a review would be sufficient and proportionate; and that a 12-month suspension would have a significant adverse impact on patients, staff, and access to NHS dental services locally, as only you hold an NHS performer number at the practice.

31. The Committee accepted the advice of the Legal Adviser.

32. The Committee had regard to the GDC's *Fitness to Practise: Guidance for the practice committees* (January 2026).

33. Misconduct must be serious. It may arise during the course of professional practice, or may involve conduct which, although not directly clinical, is morally culpable or otherwise disgraceful and liable to bring the profession into disrepute.

34. In assessing whether the facts found proved (or any of them) amount to misconduct, the Committee had particular regard to the following principles from *Standards for the Dental Team* (September 2013):

- 1.3 You must be honest and act with integrity.
- 2.2 You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.
- 2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must explain the options, including delaying treatment or doing nothing, with the risks and benefits of each, and give full information on the treatment you propose and the possible costs.

- 2.3.5 You should make sure that patients have enough information...
- 3.1 You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.
- 4.1 You must make and keep contemporaneous, complete and accurate patient records.
- 6.1 You must work effectively with your colleagues and contribute to good teamwork.
- 6.1.2 You must treat colleagues fairly and with respect, in all situations and all forms of interaction and communication. You must not bully, harass, or unfairly discriminate against them.
- 6.6 You must demonstrate effective management and leadership skills if you manage a team.
- 7.1 You must provide good quality care based on current evidence and authoritative guidance.
- 9.1 You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.
- 9.1.1 You must treat all team members, other colleagues and members of the public fairly, with dignity and in line with the law.
- 9.1.2 You must not make disparaging remarks about another member of the dental team in front of patients. Any concerns you may have about a colleague should be raised through the proper channels.
- 9.1.3 You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media, unless this is done as part of raising a concern.

35. The Committee considered the question of misconduct by the following thematic reference to its findings of fact, which span both clinical and behavioural matters:

- clinical failings relating to Patient 1 and Patient 2;
- failures of practice governance in relation to emergency medicine;
- incorrect and misleading statements made to patients in a letter dated 9 May 2022 concerning Colleague A;
- incorrect and misleading statements on your practice website; your racially motivated conduct towards Colleague B;
- your use of a racial slur;
- your conduct towards Colleague C and other colleagues;
- an offensive statement in relation to gay people; and
- the NHS claims submitted under your performer number.

36. Clinical failings relating to Patient 1 and Patient 2. In relation to Patient 1 you failed to take necessary radiographs before and after your decision to carry out root canal treatment at what you state was a healthy tooth - and before preparing teeth for a seven-unit bridge. You failed to obtain informed consent for the root canal treatment and the bridge. These

were serious clinical failings which, in the view of both experts, fell far below the standard expected of a reasonably competent dental practitioner. However, with regards to your record keeping, Professor Barker on your behalf, was of the view that your inadequate records fell below rather than far below the standard expected, whilst Mr Dhami was of the view that they fell far below. The Committee considered that the record keeping could not be viewed in isolation but had to be looked at in light of the entirety of Patient 1's appointments and the complexity of the treatment. Accordingly, the Committee agreed with Mr Dhami's assessment that your record keeping fell far below.

37. Moreover, your failure to have taken the radiographs was not because, as variously claimed by you in oral evidence, the patient refused to have radiographs taken, or because you had otherwise attempted to take radiographs but failed. In accordance with your written statement the reality was that you had made a clinical decision to proceed without radiographs, seemingly because you did not regard these to be important. You failed to discuss with Patient 1 the significantly increased risks of proceeding with such complex and invasive treatment without radiographs. Your lack of record keeping and radiographic assessment also makes it difficult to understand how the root canal treatment to an apparently healthy tooth was clinically justified.

38. In relation to Patient 2, you failed to take a pre-operative radiograph before performing an apicectomy in circumstances where you were uncertain as to which of two adjacent teeth was the source of the infection. There was no radiographic or other clinical evidence showing that an apicectomy, a complex surgical procedure involving the removal of the tip of an infected root as a last resort, was clinically justified at either tooth, one of which also had an inadequate root filling, which the experts agreed made it an inappropriate treatment for that tooth. Furthermore, you failed to obtain Patient 2's informed consent to the treatment. Again, these were serious clinical failings which, in the view of both experts, fell far below the standard expected of a reasonably competent dental practitioner. However, with regards to your record keeping, Professor Barker on your behalf, was of the view that your inadequate records fell below rather than far below the standard expected, whilst Mr Dhami was of the view that they fell far below. The Committee considered that the record keeping could not be viewed in isolation but had to be looked at in light of the entirety of Patient 2's appointments and the complexity of the treatment. Accordingly, the Committee agreed with Mr Dhami's assessment that your record keeping fell far below.

39. Your failings were not isolated but related to two patients spanning over a period of time. They involved fundamental aspects of dental practice: assessment, diagnosis, radiography, treatment planning, consent and record keeping in relation to significant, complex clinical procedures. These were particularly serious failings in the Committee's judgment and constitute misconduct.

40. Failures of practice governance in relation to emergency medicine. In 2017, you failed to maintain adequate processes, and failed to ensure adequate processes were followed, to identify and remove out-of-date Midazolam from the medical emergency drug box. The expired Midazolam had remained in the emergency drug box for approximately five months and on your account were therefore missed during at least 20 weekly checks. This put patient safety at risk in the event of the out-of-date Midazolam being administered in any emergency situation and being ineffective because it had passed its expiry date. The Committee accepted the joint expert opinion that this fell far below the standard expected of a reasonably competent dental practitioner and determined that this constitutes misconduct.

41. Incorrect and misleading statements made to patients in a letter dated 9 May 2022 concerning Colleague A. The letter incorrectly stated that Colleague A had "stolen data" from the practice and that he had been dismissed "the moment he stole patient details". Both statements were incorrect and misleading and the Committee found the second one was dishonest.

42. Although you genuinely believed it to be true (and so had not acted dishonestly in that regard), there was no evidence that Colleague A had "stolen" or otherwise misused patient data. Your incorrect and misleading statement that he had done so was a serious allegation that was both intemperate and damaging.

43. You breached the standards expected of a registered dental professional by publicly making such an allegation in the absence of any objective evidential basis. Any communication to patients about a matter so serious as a possible data breach must be accurate, objective, restrained and professional. Its purpose must be to inform patients of the relevant facts, any potential impact on them, and any remedial steps being taken. It must not be used as a vehicle for airing a private professional or commercial dispute.

44. By publicly alleging criminality or other misconduct against a named fellow practitioner, you risked damaging not only his reputation but also, therefore, public confidence in the profession. The statement was intemperate, unrestrained and self-serving. It was contained in a letter sent to a substantial number of patients and other individuals, although the exact number is unclear because there was no audit trail showing precisely how the practice had distributed the letter. The Committee determined that, even though this aspect of the letter was not dishonest, it could not be viewed in isolation but instead had to be viewed in the context of the letter as a whole, which the Committee considered was sufficiently serious to amount to misconduct.

45. Colleague A also had not been "dismissed": as you knew, he had already resigned to set up what you considered to be a rival practice (which is why you believed he had "stolen" the patient data). You had acted dishonestly in making that particular statement to give patients the impression that the practice had discovered wrongdoing and immediately

acted responsibly by dismissing him. The Committee acknowledged that you were under pressure and were in an emotionally charged state. The Committee recognised that the retaliatory and defensive nature of your false statement here is conceptually different from other forms of dishonesty, such as fraudulent claiming or the falsification of records, and so falls at the lower end of the scale of seriousness in terms of dishonest conduct.

46. However, the dishonesty still clearly meets the threshold for misconduct. As already set out, such a misleading statement, regardless of whether it was made dishonestly, would in any event have met that threshold, given the importance of patient communications being accurate, objective, evidence-based and professionally restrained, particularly where they contain serious allegations about another dental professional.

47. Incorrect and misleading statements on your practice website. These related to the practice being the "only" one in Suffolk to have invested in a new 3D very low-dose X-ray machine and to your being "one of the UK's most experienced implant dentists". The first statement was probably accurate at the time it was published but had become inaccurate as other practices in Suffolk started to introduce such technology over the years. The statement remained published because it would appear that you failed to update your website, rather than because you were trying to be misleading. The second statement appeared to reflect your subjective perception of your skills and experience at the time, again followed by a failure to update your website, rather than any deliberate attempt to mislead. Whilst the inaccurate or otherwise misleading statements on your website were in breach of professional standards, this was not, in the Committee's view, so serious a breach as to meet the threshold for misconduct. The Committee therefore determined that these matters do not amount to misconduct and so they fall away at this stage.

48. Your racially motivated conduct towards Colleague B. You insisted that Colleague B, an associate dentist at your practice, anglicise her name to [REDACTED] rather than use her real name, [REDACTED], while at work; insisted that other staff should refer to her as [REDACTED]; addressed her as [REDACTED] in emails despite her signing off as [REDACTED]; informed her that patients would not respect her if she used her real name; and told her on days when she had many patients that this was because she had changed her name to [REDACTED]. This conduct was offensive and racially motivated. Whilst you believed you were trying to support and protect Colleague B and that you wanted her to succeed professionally, your conduct was referable to race and demonstrated a discriminatory attitude. By your own admission, you treated Colleague B differently because of her name, ethnicity and perceived background.

49. The Committee considered your conduct towards Colleague B to be disgraceful. Requiring a colleague to anglicise her name because of assumptions about how patients would respond to her real name and ethnic background was offensive, discriminatory and racially motivated. It undermined Colleague B's dignity and identity. It also demonstrated a serious failure to recognise the standards of respect, equality and non-discriminatory

conduct expected of a registered dental professional. You did not merely suggest to Colleague B that she anglicise her name but repeatedly insisted that she did so, despite her objection. You even required other staff at the practice to refer to her as [REDACTED] rather than by her name. Such conduct was seriously damaging to Colleague B's sense of identity and belonging and the lasting emotional impact on her was apparent to the Committee even now some years later.

50. Whilst you believed your intention was to protect her from prejudice because of her ethnicity and background, the reality is that she suffered prejudice from you as the practice principal because her name, ethnicity and perceived background did not conform to what you considered would be acceptable for patients. You required her to suppress an important part of her identity (and the name under which she was registered with the GDC) whilst working at your practice. The Committee, therefore, was satisfied that this amounted to misconduct.

51. Your use of a racial slur. You used the N-word in front of one or more patients in the context of describing a genre of music at a boxing match. This was racially offensive, albeit not racially motivated or otherwise intended by you to cause offence. There was no evidence of hatred or hostility. Neither was there any evidence that you had used the term on any other occasion or in any other context. Your choice of language in front of Colleague C and patients was, however, deeply offensive and shocking. It reflected exceptionally poor judgment and a total lack of professionalism.

52. The fact that the Committee did not find racial motivation proved does not reduce the seriousness of the language used. Such language should never be used in a clinical or professional environment. It was capable of causing significant shock, distress or offence and of undermining public confidence in the profession. Again, on any view, your conduct constituted a serious breach of the standards expected of a registered dental professional and clearly amounts to misconduct.

53. Your conduct towards Colleague C and other colleagues. You repeatedly made comments about Colleague C's size in front of colleagues and patients. You shouted at Colleague C and called him stupid or words to that effect. You shouted at colleagues in relation to an inappropriately discarded face mask. You shouted at colleagues, including Colleague D, in relation to the rescheduling of a patient's appointment. You also insisted, in front of a patient, that Colleague C put on a belt that was too small for him, and told him that you were going to give him six months for it to fit, or words to that effect. The Committee found this conduct disrespectful, inappropriate, humiliating and unprofessional.

54. In relation to Colleague C, the comments about his size and the belt incident were demeaning and humiliating. The Committee accepted that you did not intend to be cruel or deliberately bullying. It accepted that you believed you were encouraging him or trying

to motivate him to improve his health and that you were otherwise behaving in a playful or joking manner. However, your intentions do not remove the seriousness of the impact of the conduct. The conduct reflected an over-familiar, paternal or mentoring role which you had wrongly assumed towards a subordinate junior colleague in relation to his physical appearance and personal life, coupled with a lack of self-awareness, empathy and professional boundaries.

55. The shouting incidents likewise demonstrated a failure to control your temper and exercise measured judgment. The Committee accepted that some of the underlying issues were legitimate matters for a practice principal to address, including infection control and appointment management. However, shouting, pointing, interrupting and acting in a forceful or intimidating manner towards colleagues is not acceptable professional conduct. Your position as practice principal created an imbalance of power: the subordinate colleagues to whom you directed such conduct were not necessarily able to challenge you or tell you that your conduct was unacceptable. The Committee noted the resignations of colleague C and D as a result of your behaviour.

56. The Committee determined that, because your conduct was not an isolated outburst but reflected a normalised pattern of behaviour, the breach of professional standards was serious and constituted misconduct.

57. Offensive statement in relation to gay people. You said to Colleague C words to the effect of “Do you know who make the best practice owners? Poofs”. This was offensive, albeit not intended by you to be homophobic. Whilst there was no intention to cause offence, your choice of language was inappropriate, as the term “poofs” is generally pejorative and your statement itself, intended by you to be complementary, was also underpinned by stereotypical assumptions about gay people and family life. You must reflect carefully on your use of language and how you express yourself in a clinical or other professional environment. However, the Committee did not consider this statement to a colleague in itself to constitute so serious a breach of professional standards as to meet the threshold for misconduct. The matter therefore falls away at this stage.

58. The NHS claims submitted under your performer number. You caused or permitted Colleague F to treat NHS patients when he did not have an NHS performer number and was not on the NHS performers list. Between 27 September 2021 and 24 May 2022, you submitted or allowed to be submitted claims to the NHS under your performer number for dental treatment carried out by him.

59. This was dishonest, as you intended to give the NHS the impression that you had carried out NHS-funded treatment when you had not. By allowing claims to be submitted under your NHS performer number for treatment carried out by another dentist who was not on the NHS performers list, you undermined that system. Whilst the Committee accepted that part of your motivation may have been to maintain access to NHS care, including for

children, during a difficult period, the conduct continued for approximately seven months. It was deliberate, sustained and dishonest. The Committee considered it to be a serious abuse of the trust placed in you by the NHS when submitting, or allowing to be submitted, claims under your performer number. The Committee therefore determined that this conduct clearly amounted to misconduct.

Impairment

60. The Committee next considered whether your fitness to practise is currently impaired by reason of the misconduct which it has found above.

61. The Committee had regard to whether your misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also considered whether your misconduct showed that you had in the past, and/or are liable in the future, to put patients at unwarranted risk of harm; bring the profession into disrepute; breach fundamental tenets of the profession; and act dishonestly.

62. The Committee was satisfied that, in the past, you placed patients at unwarranted risk of harm in relation to the clinical failings involving Patients 1 and 2 and the emergency medicine governance failings. As to the behavioural matters, the Committee was also satisfied that, in the past, you brought the profession into disrepute, breached fundamental tenets of the profession, and acted dishonestly.

63. The Committee considered whether you remain liable to do so again: it considered whether it could be satisfied that your misconduct is highly unlikely to be repeated.

64. You have taken a number of positive steps. You admitted many of the charges, particularly the majority of the underlying facts. You engaged with the proceedings. You have been subject to interim conditions for a significant period and have complied with them. You have undertaken CPD and reflective work. You have worked under workplace supervision with the corresponding supervisory reports available to the Committee. In the last two months, you have taken steps to obtain HR input in relation to staff matters, as you have stated that you recognise that you cannot rely solely on your own judgment. You have provided a significant number of very positive testimonials. You have apologised for aspects of your conduct and have expressed regret and remorse.

65. The Committee also recognised the passage of time since many of the events which form the basis of the findings of fact. It accepted that there has been no evidence of repetition of your misconduct in the period since the index events. It also accepted that the clinical failings are, in principle, capable of remediation. Record keeping, radiography, consent, treatment planning and clinical governance are all matters which can be remedied by training, supervision, audit, reflection and evidence of embedded improvement in practice.

66. However, the Committee was not satisfied that your remediation is complete or sufficiently embedded because of the issues identified by the Committee relating to your insight. The Committee was careful not to treat the underlying allegations which led to the warning from the Case Examiners as fact. What was alleged had not been referred for a factual inquiry and no findings of fact had been made, only an assessment of whether there was a real prospect of those matters being found proved. What is relevant is the warning itself. You had been warned about matters including consent, record keeping and diagnostic assessment. These are basic aspects of dentistry which should have held increased importance to you after being issued with a formal warning by your regulator. The fact that the Committee found similar failings, which were basic and avoidable, in the present case is a matter of significant concern and suggests that you had not taken the warning seriously and/or are still developing insight into the importance of consent, record keeping and diagnostic assessment.

67. The Committee accepted that you had undertaken a substantial amount of CPD. However, it noted that some of the most relevant CPD and reflective work appeared to have been completed relatively recently as if in performative anticipation of this hearing rather than as part of a sustained process of remediation. CPD areas appeared to be without reflection before October 2025 and more recently frequently consisted of a very short sentence, demonstrating very limited understanding of your learning and how this is embedded into your clinical practice. In particular the Committee noted two CPD courses on consent to treatment taken on 4 May 2026. The reflections on these were very limited and did not address the stated objectives and anticipated learning outcomes. For one you stated that you learned simply that "valid consent is critical before undertaking procedures". In the other CPD course you reflected that you learned "how to obtain valid consent" and that you would apply the learning by "adding consent confirmed to my notes". Given that failure to gain consent was a key element of the charges you faced the Committee was disappointed that an opportunity to demonstrate a full understanding of the issues was missed and that this could indicate a failure to fully appreciate the significance and importance of consent.

68. The Committee considered that your insight into your clinical failings is developing. You have made progress, particularly through the framework of the interim conditions and workplace supervision. However, the Committee was not satisfied that you yet demonstrate a full understanding of the importance and potential impact of the clinical failings. Whilst you have taken the first foundational steps towards your remediation in relation to the clinical matters identified in these proceedings, your insight and remediation are still developing. At this stage, the Committee could not be satisfied that your clinical failings are highly unlikely to be repeated.

69. The Committee then considered your insight into the behavioural matters. The evidence shows a recurring lack of self-awareness, measured judgment and professional restraint.

You apparently can be, on the evidence before the Committee, capable of being friendly, caring and well-meaning, as shown in the testimonials. However, the Committee considered that you can also respond impulsively and intemperately, particularly when under pressure or when you perceive yourself to be challenged.

70. Your apparent lack of self-awareness, measured judgment and professional restraint is perhaps most clearly illustrated by your deeply offensive and shocking use of the N-word in front of patients, even though it was not your intention to be racially offensive or to otherwise act in a way which might be shocking or offensive.

71. Likewise, the misleading, damaging and in one instance dishonest statements you caused to be published about Colleague A in the letter sent to patients on 9 May 2022 were indicative of a tendency to act impulsively and intemperately when under pressure. Whilst the Committee accepted that you genuinely believed Colleague A had stolen or misused patient data, you failed to step back, assess the situation objectively, and establish the facts before communicating with patients.

72. Your dishonest statement that Colleague A had been dismissed upon discovery of the alleged data breach further demonstrated a lack of measured judgment. These statements were likely to be discovered by him and challenged: they were capable of giving rise to serious professional and legal consequences to you. They were not restrained or objective communications to patients about a possible data breach, but were bound up with your personal and commercial dispute with Colleague A, which clouded your judgment and caused you to unnecessarily place yourself in the situation which you now find yourself.

73. The Committee considered that your conduct towards Colleague B demonstrated a serious lack of insight into her dignity, identity and professional standing. Again, it is characterised by a marked lack of self-awareness. The Committee accepted that you thought you were helping her. However, that is part of the problem. You did not comprehend that imposing an anglicised name on her, and linking her patient success to that imposed name, undermined her dignity and identity and prevented her from presenting herself to patients as herself. You also did not recognise that you were treating her differently because of her name, ethnicity and perceived background, and that this was discriminatory. Your later reflections show some developing awareness, but the Committee was not satisfied that your insight into the impact on Colleague B, or on other staff who witnessed that conduct, is yet sufficiently developed.

74. At this stage, the Committee considered your reflections to be characterised more by a self-focused analysis of how these matters have impacted upon you rather than on the unacceptability of your conduct and its lasting impact on others. In your reflections and apology, it does not seem that you have yet fully moved from explaining your intentions to understanding the effect of your conduct on Colleague B and on others.

75. The Committee took a similar view of your conduct towards Colleague C. It accepted that you may have intended to encourage him, and that you may have believed you had taken him under your wing in a “father-like” or mentoring role. However, you failed to appreciate the humiliating effect of repeated comments about his size, especially in front of colleagues and patients. You failed to recognise the effect of the imbalance of power between you as practice principal and him as a junior member of staff. The Committee considered that this reflected a lack of true empathy and professional boundaries and your apology and reflection show only a partial understanding of this.

76. As to your dishonesty towards the NHS, this was serious. It continued over a period of months and undermined the regulatory purpose of the NHS performer number system. The Committee accepted that the context was difficult and that part of your motivation may have been to maintain access to NHS dental care. However, your reflections do not yet show the Committee that you fully understand the importance of the scheme of NHS regulation which you had undermined, or the seriousness of submitting claims under your performer number for treatment you had not carried out.

77. Indeed, you even referred to “NHS bureaucracy” in your written reflection to the Committee, when the issue under consideration is the question of your honesty and integrity as a registered dentist who had been trusted by the NHS to submit claims for NHS-funded treatment honestly and in good faith. That language suggests that you continue to view the issue from the perspective of administrative frustration, rather than from the self-critical perspective of probity, public trust and your obligation to deal honestly with the NHS.

78. The Committee therefore concluded that there remains a risk of repetition in respect of both the clinical and behavioural matters. It does not consider these matters to be incapable of remedy but that you are still on the path of remediation. There remains a risk of repetition and therefore a continuing risk of harm to the public, which includes not only patients but also colleagues.

79. The Committee also considered the wider public interest. It was satisfied that a finding of current impairment is required to maintain public confidence in the profession and to declare and uphold proper professional standards. The findings include dishonesty, racially motivated conduct, deeply offensive racial language in front of patients, humiliating conduct towards colleagues, and clinical failings putting patients at risk. Public confidence in the profession and its regulation would be undermined if no finding of impairment were made to mark the seriousness of such conduct.

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

Sanction

81. The Committee then considered sanction.

82. The purpose of a sanction is not to punish you, although it may have a punitive effect. The purpose is to protect the public, maintain public confidence in the profession, and declare and uphold proper professional standards.

83. The Committee first considered the aggravating and mitigating factors.

84. The aggravating factors included:

- actual harm or risk of harm to patients and colleagues;
- premeditated serious dishonesty towards the NHS;
- a corresponding disregard for the NHS systems governing the profession;
- misconduct sustained or repeated over a period of time;
- clinical failings occurring after you had previously been warned by the Case Examiners about similar matters.

85. In mitigation, the Committee acknowledged that you are of previous good character, you have apologised and appear to be remorseful, you made extensive admissions to much of the Charge, you have complied with the interim conditions on your registration and there has been no evidence of repetition. The Committee also had regard to the passage of time since the index events.

86. The Committee had careful regard to the testimonials. There were 41 testimonials, the majority of which were from patients, and two of those referees gave oral evidence to the Committee. The testimonials were strongly supportive of your character and performance as a dentist. They described you as professional, kind, supportive, knowledgeable, compassionate, highly skilled, courteous, respectful and considerate. The Committee accepted that many patients and colleagues have a very positive view of the care you provide.

87. However, the Committee reminded itself that testimonials must be examined in context and the weight which can be attached to them must be assessed in light of the seriousness of the Committee's findings. The testimonials do, however, form an important part of the picture. They support the Committee's assessment that you are not a person who is cruel, malicious or indifferent. Rather, the Committee acknowledged that the testimonials indicate that you can be friendly, caring and well-meaning. However, the Committee considered that you have demonstrated a lack of sufficient self-awareness, empathy, restraint and measured judgment when interacting in a professional context.

88. The Committee also considered your insight, which is still developing. Whilst that can therefore be characterised as either a mitigating or aggravating factor depending on the way in which it is approached, the more natural view is that you have laid a foundation for your remediation and that this is encouraging. You need to continue to take remedial steps and you need to continue developing your insight through further self-critical reflection, as discussed above in the Committee's determination on impairment.

89. The Committee then considered sanction in ascending order of seriousness.

90. The Committee first considered whether to take no action or to issue a reprimand. Given the seriousness of the misconduct and the risk of repetition, the Committee determined that this would be insufficient to protect the public or to meet the wider public interest.

91. The Committee next considered whether to direct that your registration be made subject to your compliance with conditions of practice for a period of up to 36 months, with or without a review. The Committee recognised that you have already been subject to interim conditions and have complied with these. It also recognised that some of the clinical concerns are, in principle, capable of being addressed by conditions, including those requiring continued audit and supervision.

92. However, your misconduct is not confined to clinical or practice governance concerns. It includes dishonesty, racially motivated conduct, the use of offensive racial language, humiliating treatment of colleagues and still developing insight into professional behaviour. Conditions would not adequately mark the seriousness of your misconduct. Nor would conditions sufficiently address the public interest concerns arising from the dishonesty and the racially motivated conduct.

93. The Committee next considered whether to direct that your registration be suspended for a period of up to 12 months, with or without a review. Whilst neither party submitted that erasure would be appropriate in this case, the Committee must exercise its own independent judgment and therefore gave careful consideration to the ultimate sanction.

94. In doing so, the Committee had particular regard to *Grzelczak (ibid)*, which serves as a useful reminder that racially motivated misconduct is to be treated seriously, but that it does not follow that such misconduct is necessarily irremediable or fundamentally incompatible with continued registration. The relevant consideration is whether, on the facts of the individual case, the attitudinal failing is so entrenched or irremediable that no lesser sanction than erasure would be sufficient to protect the public and to meet the wider public interest.

95. The Committee considered that suspension is the necessary and proportionate sanction in this case. Your misconduct is particularly serious, but not, in the Committee's judgment, so fundamentally incompatible with continued registration that erasure is required. Whilst

the facts of this case engage the question of erasure, the Committee considered from all the information before it together with your developing insight that whilst you have concerning attitudinal traits you do not demonstrate harmful deep-seated personality or professional attitudinal problems which might make erasure the appropriate outcome. Whilst your misconduct encompasses significant behavioural and attitudinal failings, those failings are not irredeemable and are not characterised by a personality which is intentionally cruel or offensive. Your apology and remorse appear genuine, even if your related insight is still developing. The Committee reminded itself that erasure is the sanction of last resort and should only be imposed when no lesser sanction would protect the public or meet the public interest.

96. The Committee gave careful consideration to whether a shorter period of suspension would be sufficient and proportionate. It concluded that it would not. This was not a case involving a single isolated failing or a narrow area of remediable clinical practice. The misconduct was wide-ranging and included serious clinical failings, dishonesty towards patients and the NHS, racially motivated conduct, the use of deeply offensive racial language in front of patients, and humiliating conduct towards colleagues. The Committee has found that your insight is developing, but not yet sufficiently complete or embedded. In particular, you need time to undertake and evidence sustained remediation in relation to insight and reflection not only to clinical governance, consent, radiography and record keeping, but also probity, equality and diversity, anti-racism principles, workplace behaviour, professional boundaries, emotional regulation and measured judgment. A short suspension would not adequately reflect the seriousness of the misconduct, nor would it give sufficient time for you to demonstrate a commitment to the necessary changes in your approach and attitude. The Committee therefore determined that a 12-month suspension is the minimum period necessary and proportionate to protect the public, maintain public confidence in the profession, uphold proper professional standards and allow meaningful remediation to take place.

97. Whilst a lengthy period suspension might have a significant impact on the continuity of care for your NHS patients, those consequences cannot override the need to protect the public and the public interest.

98. Accordingly, the Committee directs that your registration be suspended for a period of 12 months. The period of suspension shall be reviewed prior to its expiry, when you will need to persuade the reviewing committee that your fitness to practise is no longer impaired. The reviewing Committee may be assisted by: further evidence that you have maintained and built upon the remediation which has begun, this should include evidence of CPD and detailed, meaningful reflections on the issues addressed at this hearing; a substantive and updated reflection statement demonstrating insight into your misconduct, its impact on patients, colleagues and the profession and how you will avoid repetition.

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

The interim order on your registration is hereby revoked.

Ms Tahta applied for an immediate suspension order under section 30(1) of the Dentists Act 1984 on the grounds that this is necessary for the protection of the public and is otherwise in the public interest.

Mr Haycroft submitted that an immediate order is not necessary to cover the 28-day appeal period. He submitted that you had conceded misconduct and impairment. Whilst the Committee has found a continuing risk of repetition, there has been no evidence of repetition and any risk would therefore be theoretical during the next 28-days. He further submitted that the practical effect of an immediate order would be to suspend you for 13 months, rather than the 12 months directed by the Committee; and that the immediacy of the suspension would also interrupt the continuity of care for your NHS patients.

The Committee accepted the advice of the Legal Adviser.

The Committee determined that it is necessary for the protection of the public and is otherwise in the public interest to make an immediate suspension order. The Committee has found a risk of repetition of both the clinical and behavioural matters, with a continuing risk of harm to the public. The behavioural matters also encompass serious dishonesty against the NHS and racially motivated conduct, which engages the public interest to a high degree. It would be inconsistent with the above determination not to make an immediate order.

The effect of this order is that your registration is now immediately suspended. Unless you exercise your right of appeal, the substantive 12-month period of suspension will take effect 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.

That concludes this determination.