General
Dental
Council

HEARING PARTLY HEARD IN PRIVATE*

*The Committee has made a determination in this case that includes some private information. That information has been omitted from the text.

Registration No:238749

PROFESSIONAL CONDUCT COMMITTEE

JANUARY-MAY 2022

Outcome: Erased with Immediate suspension

HASHMI, Aasim Siddique, a dentist, BChD University of Leeds 2012, was summoned to appear before the Professional Conduct Committee on 10 January 2022 for an inquiry into the following charge:

Charge (as amended as AMENDED and READ on 12 January 2022)

"That, being a registered dentist,

1. Between April 2014 and 18 March 2018 you were in practice as an Associate at Practice 1 ('the Practice') (referred to in Schedule A[1]).

2. You provided care and treatment under private contract to the patients set out in Schedule A.

Implant & Orthodontic Patients

Patient 2

3. You failed to maintain adequate records between 10 May 2017 and 26 February 2018 in that you did not record, adequately or at all:
   (a) a comprehensive orthodontic assessment;
   (b) the treatment plan or objectives of treatment;
   (c) oral hygiene status including a Periodontal Examination ('BPE');
   (d) obtaining informed consent to:
      (i) orthodontic treatment;
      (ii) Interproximal Reduction ("IPR")
   (e) the amount of IPR carried out and on which precise teeth;
   (f) treatment provided at every appointment.

4. You failed to carry out an adequate orthodontic assessment.

Patient 3

5. You failed to maintain adequate records between 11 December 2017 and about 5 March 2018 in that you did not record, adequately or at all:

[1] Schedule a is a private document that cannot be disclosed.

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) oral hygiene status including a BPE;

(d) obtaining informed consent to orthodontic treatment;

(e) record and/or report of findings in respect of undated radiographs including an OPG;

(f) treatment provided at every appointment;

6. You failed to carry out an adequate orthodontic assessment.

7. You failed to obtain informed consent to treatment in that Patient 3 was not adequately advised of the risks associated with her pre-existing root resorption.

8. You inappropriately provided orthodontic treatment when Patient 3 was not a suitable candidate given root resorption at UL1-2 and UR1-2.

9. Between 25 April 2018 and at least 24 March 2020 you failed to respond to communications from Patient 3's solicitors in connection with a potential claim against you for the orthodontic treatment you provided to Patient 3 between about January 2018 and March 2018.

Patient 4

10. You failed to maintain adequate records between 2 May 2017 and 14 March 2018 in that you did not record, adequately or at all:

(a) the patient's previous dental history;

(b) an examination of hard and/or soft tissues;

(c) dental charting;

(d) oral hygiene status;

(e) a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;

(f) a record and/or report of findings in respect of DPT radiographs taken on or about:

(i) 21 June 2017;

(ii) 14 March 2018;

(g) the provision of treatment on 21 June 2017 involving the placement of implants at LL3 and LR3;

(h) discussion with the patient regarding treatment options for the upper jaw including risks and benefits;

(i) a diagnosis of periodontal disease and/or your rationale for the removal of the remaining teeth in the upper jaw on 30 October 2017;

(j) a treatment plan involving the removal of upper teeth.

11. You placed implants at LL3 and LR3 which were angled divergently to each other

rather than parallel.

12. You failed:

    (a) to adequately assess the patient prior to the placement of implants in the lower jaw;

    (b) to adequately plan the placement of implants in the lower jaw including with the use of stents or similar.

    13. In providing treatment to Patient 4 you acted outside the limits of your competence.

Patient 5

14. You failed to maintain adequate records between 17 July 2017 and about March 2018 in that you did not record, adequately or at all:

    (a) a comprehensive orthodontic assessment;

    (b) the treatment plan or objectives of treatment;

    (c) a report of findings in respect of an OPG recorded as having been taken on 8 August 2017;

    (d) obtaining informed consent to:

        (i) orthodontic treatment;

        (ii) IPR;

    (e) the amount of IPR carried out and on which precise teeth;

    (f) treatment provided at every appointment.

15. You failed to carry out an adequate orthodontic assessment.

16. You inappropriately commenced orthodontic treatment without first securing Patient 5's periodontal health.

Patient 6

17. You failed to maintain adequate records between 2 August 2017 and about March 2018 in that you did not record, adequately or at all:

    (a) a comprehensive orthodontic assessment;

    (b) the treatment plan or objectives of treatment;

    (c) oral hygiene status including BPE;

    (d) the taking of study models;

    (e) obtaining informed consent to orthodontic treatment;

    (f) treatment provided at every appointment.

18. You failed to carry out an adequate orthodontic assessment.

Patient 10

19. You failed to maintain adequate records between 8 September 2017 and about March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) oral hygiene status including BPE;

(d) the taking of study models;

(e) obtaining informed consent to orthodontic treatment;

(f) treatment provided at every appointment.

20. You failed to carry out an adequate orthodontic assessment.

Patient 11

21. You failed to maintain adequate records between 7 December 2016 and 11 December 2017 in that you did not record, adequately or at all:

(a) the patient's previous dental history;

(b) an examination of hard or soft tissues;

(c) dental charting;

(d) oral hygiene status;

(e) a diagnosis of chronic periodontal disease and/or your rationale for the removal of the remaining teeth in the lower jaw;

(f) a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;

(g) a record and/or report of findings in respect of:

(i) a DPT taken on 7 December 2017;

(ii) a CBCT taken on 13 March 2018;

(iii) two DPTs taken on 4 April 2017;

(iv) an undated DPT taken after the implants were uncovered;

(h) discussion with the patient regarding treatment options including risks and benefits;

(i) a treatment plan involving the removal of lower teeth and implants at LL3 and LR3;

(j) the provision of treatment between 13 March 2017 and 11 December 2017 involving:

(i) removal of lower teeth;

(ii) conversion of lower partial denture to a full denture;

(iii) the placement of implants at LL3 and LR3 on about 4 April 2017;

(iv) further treatment at LR3 thereafter.

22. You failed:

(a) to adequately assess the patient prior to the provision of implants;

(b) to adequately diagnose, adequately monitor and/or adequately treat periodontal disease prior to the provision of implants.

23. You ought not to have placed implants at LR3 and LL3 as Patient 11 was not a suitable candidate for implants given her chronic periodontal disease.

Patient 12

24. You failed to maintain adequate records between 18 April 2017 and 5 March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) a medical history;

(d) a record and/or report of findings of an undated OPG;

(e) the amount of IPR carried out and on which precise teeth;

(f) treatment provided at each appointment.

25. You failed to carry out an adequate orthodontic assessment.

26. You inappropriately commenced orthodontic treatment without first securing Patient 12's periodontal health.

Patient 13

27. You failed to maintain adequate records between 29 September 2017 and about March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) oral hygiene status including BPE;

(d) the taking of study models;

(e) a medical history;

(f) a record and/or report of findings of an undated OPG;

(g) the amount of IPR carried out and on which precise teeth;

(h) treatment provided at each appointment.

28. You failed to carry out an adequate orthodontic assessment.

29. You removed excessive enamel from:

(a) UL2;

(b) LR1.

Patient 15

30. You failed to maintain adequate records between 19 February 2018 and 14 March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) oral hygiene status including BPE;

(d) treatment provided at each appointment.

31. You failed to carry out an adequate orthodontic assessment.

32. You failed to obtain consent to treatment in that Patient 15 was not adequately advised of the outcome of treatment using only Quick Straight Teeth ('QST') appliances.

33. You inappropriately provided two arch treatment with QST appliances when Patient 15 was not a suitable candidate given her complex malocclusion.

34. In providing treatment to Patient 15 you acted outside the limits of your competence.

Patient 16

35. You failed to maintain adequate records between 30 October 2017 and about March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) a medical history;

(d) a record and/or report of findings of undated radiographs including an OPG;

(e) obtaining informed consent to orthodontic treatment;

(f) treatment provided at each appointment.

36. You failed to carry out an adequate orthodontic assessment.

37. You inappropriately provided orthodontic treatment without first securing the Patient 16's periodontal health.

Patient 19

38. You failed to maintain adequate records between a date prior to 21 June 2017 and about March 2018 in that you did not record, adequately or at all:

(a) a comprehensive orthodontic assessment;

(b) the treatment plan or objectives of treatment;

(c) oral hygiene status including BPE;

(d) obtaining informed consent to:

(i) orthodontic treatment;

(ii) IPR;

(e) the amount of IPR carried out and on which precise teeth;

(f) the details of enameloplasty provided in the upper arch;

(g) treatment provided at each appointment.

39. You failed to carry out an adequate orthodontic assessment.

Patient 21

40. You failed to maintain adequate records between 14 August 2017 and about November 2017 in that you did not record, adequately or at all:

    (a) the patient's previous dental history;

    (b) an examination of hard or soft tissues;

    (c) dental charting;

    (d) oral hygiene status;

    (e) a clinical evaluation of height and/or width of proposed implant site or sites in the lower arch;

    (f) record and/or report of findings in respect of:

        (i) any pre-operative DPT radiographs;

        (ii) a post-operative DPT taken on 27 September 2017;

        (iii) a PA radiograph taken on 27 September 2017;

    (g) discussion with the patient regarding treatment options including risks and benefits;

    (h) a treatment plan involving an implant at LL4;

    (i) the provision of treatment involving the placement of an implant at LL4 on 27 September 2017;

    (j) the rationale for the placement on one implant only on 27 September 2017 when a second implant was required for an implant retained bridge at LL4-LL7.

41. You failed:

    (a) to carry out any, or any adequate, radiographic assessment of the proposed implant site or sites;

    (b) to carry out any, or any adequate, assessment of the patient's periodontal status.

42. You inappropriately placed only one implant in the lower left quadrant on 27 September 2017 when two were indicated to achieve long term retention of the planned implant supported bridge at LL4-LL6.

43. In providing treatment to Patient 21 you acted outside the limits of your competence.

Patient 22

44. You failed to maintain adequate records between 21 December 2016 and 17 November 2017 in that you did not record, adequately or at all:

    (a) the patient's previous medical history;

    (b) the patient's previous dental history;

    (c) an examination of hard or soft tissues;

    (d) dental charting;

(e) oral hygiene status;

(f) a diagnosis of periodontal disease and/or your rationale for the removal of the remaining teeth in the upper and lower jaws;

(g) a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;

(h) a record and/or report of findings in respect of:

(i) a DPT taken on 21 December 2016;

(ii) PA radiographs and a DPT taken on 25 August 2017

(iii) a CBCT dated 13 June 2017;

(i) treatment provided on 25 August 2017 including the placement of implants and the subsequent fitting of a lower overdenture.

45. When discussing treatment options, you inappropriately:

(a) offered a partial chrome denture on 21 December 2016 which was not suitable given the status of the remaining teeth;

(b) offered root canal therapy and crowns on 15 February 2017 which were not suitable given the status of the remaining teeth.

Patient Payments

46. Between about 29 July 2017 and 18 March 2018 whilst working at the Practice you obtained payments directly from patients:

(a) in cash which you retained;

(b) by transfer direct to your own personal bank account.

47. You concealed from the Practice the payments you obtained from patients.

48. You concealed from patients that their payments ought not to have been paid to you.

49. Your conduct as set out above at 46(a) and/or 46(b) and/or 47 and/or 48 was:

(a) misleading;

(b) dishonest in that you knew you were not entitled to:

(i) take patient payments directly; and/or

(ii) retain patient payments.

Advertising

50. On 22 January 2018 you were advised by the Case Examiners for the GDC to ensure, words to the effect, that any advertising:

(a) was accurate and did not have the potential to mislead;

(b) did not permit for any ambiguity about your healthcare training.

51. From July 2018 or earlier, you advertised yourself to prospective patients as being an 'Experienced Cosmetic Dentist' having undertaken, amongst other things, a 'Diploma in Facial Aesthetics'.

52. The 'Diploma in Facial Aesthetics' is not a dental qualification.

53. Your conduct in respect of your advertising was:

    (a) misleading;

    (b) dishonest in that you knew it was liable to mislead as to your dental qualifications.

Indemnity

54. Between 10 February 2013 and about 21 January 2019 you failed to ensure you had adequate indemnity insurance in that:

    (a) in February 2013 you took out insurance on the basis you had commenced Foundation Training when you had not;

    (b) you thereafter renewed your insurance annually on the basis that you had commenced and/or completed Foundation Training when you had not;

    (c) from about 2016 your practice included the provision of implants which was not covered by your insurance.

55. Your conduct in relation to charge 54 above was:

    (a) misleading,

    (b) dishonest.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of:

    i. Deficient Professional Performance in respect of charges 3- 8 and 10 - 45; and/or

    ii. Misconduct."

Mr Hashmi was present and represented only for the postponement application on 10 and 11 January 2022. On 11, 12 and 21 January 2022, the Chairman made statements regarding the preliminary applications.

DETERMINATION ON POSTPONEMENT APPLICATION – 11 January 2022

"Mr Hashmi

You are present at this hearing of the Professional Conduct Committee (PCC). You are represented by Mr Ashley Serr of Counsel, instructed by Adkirk Law, who appears for you solely for the purposes of an application for the hearing to be postponed. Ms Lydia Barnfather of Counsel, instructed by Capsticks solicitors, appears for the General Dental Council (GDC).

The hearing is being held remotely using Microsoft Teams in line with the GDC's current practice.

Preliminary matters

At the outset of the hearing on 10 January 2022 Mr Serr on your behalf made an application under Rule 58 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules') to postpone the hearing.

Before hearing the application the Committee invited parties to consider whether an application should be made under Rule 53 of the Rules for the application to be heard in private. Mr Serr on your behalf submitted that the application should be heard in private, given that the application relates to your health. Ms Barnfather invited the Committee to consider whether all matters need to be heard in private. Having accepted the advice of the Legal Adviser, the Committee decided to hear the entire application for a postponement in private. It considered that it would be impractical, if not impossible, for some matters to be heard in public.

The Committee then proceeded to hear argument as to whether the hearing should be postponed.

[IN PRIVATE]

IN PUBLIC

In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser.

The Committee has considered the application to postpone under Rule 58 of the Rules. Rule 58 (4) states as follows:

58 (4) In considering whether or not to grant a request for postponement or adjournment, a Committee shall, amongst other matters, have regard to –

(a) the public interest in the expeditious disposal of the case;

(b) the potential inconvenience caused to a party or any witness to be called by that party; and

(c) fairness to the respondent.

The Committee has determined not to accede to your application for a postponement of this hearing.

[IN PRIVATE]

IN PUBLIC

The Committee has determined that the absence of legal representation to support you for the remainder of the hearing is not a sufficient reason to postpone the hearing in the particular circumstances of this case. The Committee notes that you have a history of engagement with the GDC and a history of representation by solicitors and a barrister. You have had the benefit of legal advice, assistance, representation and preparation for a considerable period of time. The Committee has been informed that you dispensed with such representation for a period of approximately two weeks, and then re-engaged with lawyers for the purposes of preparing and presenting your application for a postponement. In that time when you dispensed with your legal representation, instructed Counsel became unavailable and is no longer able to represent you for this January listing. The Committee is mindful of the benefits that legal representation brings, and it is also mindful that you face a number of allegations, including serious allegations, which if found proven may have consequences for your registration. However, it notes that you have had the opportunity to have legal representation and that the difficulties have arisen from funding issues. You have received legal assistance and are currently represented at this hearing for the purposes of your postponement application, which has been made very recently, and the Committee also

notes the GDC's submission that you are 'trial ready'. Indeed, as noted above, the Committee has been provided with a considerable amount of documentary evidence submitted on your behalf in relation to the allegations that you face, including your witness statement and reports from two expert witnesses. The Committee has heard that you would admit to the vast majority of the allegations that you presently face.

In considering your application to postpone against this background, the Committee is not persuaded that a postponement is required in order to ensure fairness to you. The Committee has also again had regard to the potential inconvenience that would be caused to the GDC and its witnesses as well as with the public interest in seeing an expeditious consideration of this case. The Committee considers that there are clear and compelling reasons to proceed with the hearing at this time, as dates have been agreed and witnesses' attendance has been secured. The Committee is once more mindful of the potential inconvenience that would be caused to the GDC and its witnesses if it were to decide to postpone the hearing, including the ability of witnesses to attend on different dates and of the effect on their recollection of the events in question. The Committee does not share Mr Serr's estimate that the entire hearing could be heard and concluded in the space of one week if the matter were to be postponed to the reserved dates in May 2022. The Committee is again mindful of the public interest in seeing an expeditious consideration and disposal of this case.

Therefore, taking into account of the information and submissions presented to it, and having weighed your interests against the public interest and the potential inconvenience caused to witnesses, the Committee is not satisfied that any unfairness caused to you by not having legal representation at this time means that the hearing should be postponed.

The Committee also considers that, when looking at your application for postponement on health and legal grounds separately as well as cumulatively, there are insufficient grounds to accede to your request. The Committee has therefore determined to refuse your application for a postponement.

The Committee has heard that you are minded to withdraw from these proceedings if it were to determine not to accede to your application for a postponement. The Committee would encourage you to continue to participate in the hearing, and it reminds you that you are entitled to do so, or to re-engage with the hearing at any time if it proceeds to determine to continue with the hearing in your absence if you withdraw.

The Committee has also considered Mr Serr's alternative proposal for it to defer 'stage two' of the hearing to the dates set aside in May 2022. The Committee makes no such direction and will instead determine how best to proceed if and when it reaches the end of 'stage one' of this case.

That concludes this determination."

DETERMINATION ON SERVICE OF NOTICE OF HEARING, PROCEEDING IN ABSENCE AND RULE 25 APPLICATION – 12 January 2022

"The hearing is being held remotely using Microsoft Teams in line with the GDC's current practice. Mr Hashmi is not now present and is not represented in his absence. Ms Lydia Barnfather of Counsel, instructed by Capsticks solicitors, appears for the GDC.

Preliminary matters

The Committee's decision to refuse Mr Hashmi's application for a postponement of this hearing is set out in a separate determination dated 11 January 2022.

Following the handing down of the determination on postponement on the afternoon of 11 January 2022, at which time Mr Hashmi and his representative, namely Mr Ashley Serr of Counsel, were present, Mr Serr invited the Committee to adjourn the hearing until the morning of 12 January 2022 to allow Mr Hashmi to consider his position and to speak to his legal team. The Committee acceded to the application and adjourned the hearing until 0930 hours on 12 January 2022.

The hearing resumed on the morning of 12 January 2022. Mr Hashmi was noted to be not in attendance and was not represented in his absence.

Ms Barnfather addressed the Committee in respect of service of the notice of hearing and proceeding in Mr Hashmi's absence. Ms Barnfather submitted that service of the notice of hearing was properly effected in accordance with the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'), not least by reference to Mr Hashmi's participation in the hearing on 10 and 11 January 2022.

Ms Barnfather further invited the Committee to proceed in Mr Hashmi's absence pursuant to Rule 54 of the Rules. She submitted that Mr Hashmi has voluntarily waived his right to attend and has purposefully absented himself from the hearing. Ms Barnfather submitted that any further adjournment would not serve any useful purpose. After a short adjournment Ms Barnfather stated that she had received an email from Mr Hashmi's legal representatives, namely Adkirk Law, who had been acting for Mr Hashmi, which states that, 'Mr Hashmi has confirmed he is not attending the hearing for the reasons he has already given. I however suggest you contact him directly as the hearing develops.'

The Committee accepted the advice of the Legal Adviser.

The Committee was first of all satisfied that service of the notice of hearing has been properly effected in accordance with the Rules. The Committee notes that the notice of hearing dated 9 December 2021 set out the date and time of this hearing, as well as its remote nature. The notice was sent using the Royal Mail's Special Delivery postal service, as well as by first class post and email. The Committee considers that Mr Hashmi's safe receipt of the notice was demonstrated by his attendance at the hearing on 10 and 11 January 2022.

The Committee then went on to consider whether to proceed in Mr Hashmi's absence. The Committee finds that Mr Hashmi has deliberately and voluntarily absented himself from the continuation of these proceedings. The email received from Mr Hashmi's legal representatives on 12 January 2022 states that Mr Hashmi will not be in attendance. The Committee considers that a further adjournment would serve little purpose. The Committee was also mindful of the public interest in seeing an expeditious consideration of the matters giving rise to this hearing. Therefore, the Committee decided to proceed in the absence of Mr Hashmi.

Ms Barnfather then made an application under Rule 25 (2) of the Rules to add a further head of charge to those that you already face.

On 9 December 2021 Capsticks solicitors wrote to you to state that, during the course of its investigation of the matters giving rise to this hearing, it obtained information suggesting that you had failed to engage with the solicitor acting for one of the patients to whom the heads of charges relate, who is referred to as Patient 3, in connection with the orthodontic

treatment that you provided to that patient. In their letter Capsticks stated that they proposed to make an application for a further head of charge dealing with that additional allegation to be considered alongside the heads of charge that you already face.

Ms Barnfather submitted that the new allegation is similar in nature and is founded on the same alleged facts. Ms Barnfather also submitted that prior to absenting themselves Mr Hashmi and his legal representatives made no objection to the Rule 25 application.

Before coming to a decision on the Rule 25 application the Committee invited Ms Barnfather's submissions on whether to make minor amendments to the heads of charge. The Committee drew Ms Barnfather's attention to the new head of charge, to be numbered (9), and proposed that the word, 'to' be inserted to aid understanding, so that the relevant part read, '[…] the orthodontic treatment you provided *to* [emphasis added] Patient 3 […]'. Ms Barnfather made no objection. The Committee also drew Ms Barnfather's attention to the head of charge which is now numbered (49). Ms Barnfather invited the Committee to amend the charge so that the alleged facts giving rise to the allegation at head of charge (49) are referenced correctly in light of the Rule 25 decision. Ms Barnfather also clarified that, in terms of the charges of misconduct and deficient professional performance as referred to at the foot of the heads of charge, the GDC's primary case will be that all of the facts alleged at each head of charge amount to misconduct. Ms Barnfather submitted that, if the Committee were to find that some or all of the heads of charge at (3) to (8) and (10) to (45) do not amount to misconduct, the Committee would then determine whether those heads of charge amount to deficient professional performance.

The Committee accepted the advice of the Legal Adviser.

The Committee determined to accede to the application. The Committee notes that, in relation to Rule 25 (2), allegations have been referred to this Committee, that the allegations have not been heard, and that the new allegation is similar in nature and is founded on the same alleged facts. The Committee considers that no injustice would be caused to Mr Hashmi, as he has been provided with sufficient notice of the GDC's intention to seek to add this new allegation to the allegations that he already faces.

The Committee also determined to amend heads of charge (9) and (49) as referred to above in accordance with Rule 18. The Committee was satisfied that it was fair and appropriate for the minor amendments to be made, as they would bring greater clarity to those heads of charge. The Committee considered that no injustice would be caused to Mr Hashmi by making these small changes."

DETERMINATION ON AMENDMENT TO HEADS OF CHARGE AND ON ADJOURNMENT – 21 January 2022

"The registrant is not currently present at this hearing of the Professional Conduct Committee (PCC). Ms Lydia Barnfather of Counsel, instructed by Capsticks solicitors, appears for the General Dental Council (GDC).

The hearing is being held remotely using Microsoft Teams in line with the GDC's current practice.

Adjournment of the hearing and amendment to heads of charge

On 21 January 2022 the hearing resumed in session. The Committee announced that it remained in camera at the factual stage of its inquiry. The Committee announced that it

would not be in a position to deliver its factual findings in the time remaining for the hearing, that is to say by the close of business on 21 January 2021. The Committee announced that it would hear representations under Rule 58 (2) of the 32TGeneral Dental Council (Fitness to Practise) Rules 2006 ('the Rules') in relation to an adjournment of the hearing, with a view to the hearing resuming on the dates already set aside for its continuation, namely 9 to 13 May 2022.

Ms Barnfather first addressed the Committee under Rule 18 in light of further legal advice given to the Committee and repeated in session relating to heads of charge 21 (g) (i) and 21 (g) (ii). Ms Barnfather submitted that the gravamen of the head of charge is not affected by the dates attributed to the heads of charge. Ms Barnfather submitted that amendments to the heads of charge can be properly made so that the year end specified in those heads of charge is corrected.

The Committee accepted the advice of the Legal Adviser, including the advice given in camera and repeated in open session.

The Committee determined not to accede to Ms Barnfather's application under Rule 18. The Committee considers that undue unfairness would be caused to Mr Hashmi were it to allow the application at this late stage, namely following the closing of the GDC's factual case.

The Committee then returned to hear representations on the matter of adjournment under Rule 58 (2).

Ms Barnfather stated that the Committee must take the time that it requires to continue its deliberations. Ms Barnfather did invite the Committee to consider whether it could continue and conclude its factual determination prior to the previously scheduled resuming dates of 9 to 13 May 2022 so that, when the hearing resumes in session on 9 May 2022, parties will have been provided with the Committee's factual determination.

The Committee has accepted the advice of the Legal Adviser.

The Committee has determined to adjourn the hearing as there is insufficient time remaining to continue the hearing. In short, the Committee has no alternative but to adjourn.

The Committee also accedes to Ms Barnfather's suggestion of scheduling further dates before May 2022 for the Committee to continue its deliberations on the facts. The Committee will use the remainder of 21 January 2022 to continue its factual deliberations in camera. The Committee directs that the GDC's Hearings team identify up to four days before 9 May 2022 for the Committee to continue those in camera discussions. If the Committee conclude their factual deliberations in those additional days, the Committee may decide to direct that its factual determination be sent to parties under embargo in advance of resuming on 9 May 2022. Parties are not required to be in attendance on those additional four days if they are able to be scheduled but will be notified at the end of those four days as to whether the Committee will return in session on the morning of 9 May 2022 or instead whether the Committee requires further time to continue and conclude its factual deliberations. If it proves not possible to schedule those additional four days before 9 May 2022, the hearing will simply resume as originally anticipated on 9 May 2022.

The previously scheduled dates of 9 to 13 May 2022 are unaffected. Parties should make themselves available for the week of 9 to 13 May 2022 for the continuation of the hearing.

The Committee further directs that a copy of this determination be sent to Mr Hashmi and those acting for him.

That concludes this determination."

The hearing adjourned on 21 January 2022 and resumed on 9 May 2022.

On 10 May 2022 the Chairman announced the findings of fact to the Counsel for the GDC:

FINDINGS OF FACT – 10 May 2022

"The hearing is being held remotely using Microsoft Teams in line with the General Dental Council's (GDC's) current practice. Save for the first two days of the hearing, namely 10 and 11 January 2022, Mr Hashmi is not in attendance and is not represented in his absence. Ms Lydia Barnfather of Counsel, instructed by Capsticks solicitors, appears for the GDC.

Preliminary matters

The Committee's decision to refuse Mr Hashmi's application for a postponement of this hearing is set out in a separate determination dated 11 January 2022.

On 12 January 2022 Ms Barnfather made an application under Rule 54 to proceed in Mr Hashmi's absence. Ms Barnfather made an application later that same day under Rule 25 (2) of the Rules to add further heads of charge to those that Mr Hashmi already faces, and to make minor amendments to two other heads of charge pursuant to Rule 18. The Committee's decisions in respect of those applications are set out separately in the same determination dated 12 January 2022.

On 21 January 2022 the Committee returned from its deliberations so that legal advice provided *in camera* could be repeated in open session. Ms Barnfather made an application to amend heads of charge 21 (g) (i) and 21 (g) (ii). The Committee's determination arising from Ms Barnfather's application is set out in a separate determination dated 21 January 2022.

Background to the case and summary of allegations

The allegations giving rise to this hearing relate to the standard of care and treatment that Mr Hashmi provided to 14 patients. Mr Hashmi saw the patients on a private basis from April 2014 to March 2018 whilst an associate at a dental practice at which he worked. Mr Hashmi also faces allegations relating to payments obtained directly from patients, to his advertising practices, and to his indemnity insurance arrangements.

The allegations may be summarised as follows.

Patient 2

It is alleged that Mr Hashmi failed to maintain adequate records for Patient 2 in the period of 10 May 2017 to 26 February 2018, with particular reference to orthodontic assessment, treatment planning and provision, oral hygiene status, informed consent and the amount of interproximal reduction (IPR) carried out and on which teeth. It is further contended that Mr Hashmi failed to carry out an adequate orthodontic assessment.

Patient 3

The GDC alleges that Mr Hashmi failed to maintain adequate records for Patient 3 in the period of 11 December 2017 to around 5 March 2018, again with particular regard to orthodontic assessment, treatment planning and provision, oral hygiene status, informed

consent and a record of or report on radiographic findings. It is further alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment.

It is further contended that Mr Hashmi failed to obtain informed consent from Patient 3, and that he provided orthodontic treatment when it was not appropriate for him to do so. It is also alleged that, subsequently and for a period of approximately two years, Mr Hashmi failed to respond to communications from Patient 3's solicitors in relation to a potential claim arising out of the orthodontic treatment that he had provided.

Patient 4

The GDC brings allegations against Mr Hashmi that he failed to maintain adequate records in respect of his treatment of Patient 4 in the period of 2 May 2017 and 14 March 2018, with particular regard to the patient's dental history, examinations and evaluations, record of and report on radiographic findings, dental charting, discussion of treatment options, treatment planning and provision, and diagnosis of periodontal disease or a rationale for removing teeth.

It is also contended that Mr Hashmi placed implants at two sites, namely LL3 and LR3 which, rather than being parallel, were angled divergently to one another.

The GDC also brings allegations that Mr Hashmi failed to adequately assess Patient 4 before placing implants in the patient's lower jaw, and failed to adequately plan the placement of those implants.

The GDC alleges that Mr Hashmi acted outside the limits of his competence in providing treatment to Patient 4.

Patient 5

The GDC alleges that Mr Hashmi failed to maintain adequate records for Patient 5 in the period of 17 July 2017 to around March 2018, with particular reference to orthodontic assessment, treatment planning and provision, a report on radiographic findings, informed consent, and the amount of IPR carried out and on which teeth. It is also alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 5, and inappropriately commenced treatment without having secured the patient's periodontal health beforehand.

Patient 6

It is alleged that Mr Hashmi failed to maintain adequate records for Patient 6 in the period of 2 August 2017 to around March 2018 in relation to orthodontic assessment, treatment planning and provision, oral hygiene status, informed consent and the taking of study models. It is again alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 6.

Patient 10

The heads of charge that Mr Hashmi faces in relation to Patient 10 are that he failed to maintain adequate records between 8 September 2017 and approximately March 2018 with reference to orthodontic assessment, treatment planning and provision, oral hygiene status, informed consent and the taking of study models. It is again alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 10.

Patient 11

It is alleged that Mr Hashmi failed to maintain adequate records for Patient 11, with regard to treatment planning and provision, the patient's dental history, patient examination, clinical evaluation and charting, oral hygiene status, diagnosis of periodontal disease or a rationale for removing teeth, a record of or report on radiographic findings, and discussions about treatment options.

It is further contended that Mr Hashmi failed to adequately assess the patient prior to providing implants, and failed to adequately diagnose, monitor and treat the patient's periodontal disease before implants were provided. The GDC also suggests that Mr Hashmi should not have placed implants at the patient's LR3 and LL3 as the patient was not a suitable candidate for implants given her chronic periodontal disease.

Patient 12

The heads of charge that Mr Hashmi faces in relation to Patient 12 are that he failed to maintain adequate records between 18 April 2017 and 5 March 2018, with regard to orthodontic assessment, treatment planning and provision, a record of and report on radiographic findings, medical history, and the amount of IPR carried out and on which teeth. It is also alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 12, and inappropriately commenced treatment without having secured the patient's periodontal health beforehand.

Patient 13

The heads of charge that Mr Hashmi faces in relation to Patient 13 are that he failed to maintain adequate records between 29 September 2017 and around March 2018, with regard to orthodontic assessment, treatment planning and provision, oral hygiene status, the taking of study models, a record of and report on radiographic findings, medical history, and the amount of IPR carried out and on which teeth. It is also alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 13, and that he removed excessive enamel from the patient's UL2 and LR1.

Patient 15

The GDC alleges that Mr Hashmi failed to maintain adequate records in respect of Patient 15 in the period of 19 February 2018 and 14 March 2018, with particular regard to orthodontic assessment, treatment planning and provision, and oral hygiene status.

It is also contended that Mr Hashmi failed to conduct an adequate orthodontic assessment, failed to obtain informed consent, and provided treatment that was not appropriate for the patient. The GDC also alleges that, in providing treatment to Patient 15, Mr Hashmi acted outside of the limits of his competence.

Patient 16

It is alleged that, in respect of Patient 16, Mr Hashmi failed to maintain adequate patient records between 30 October 2017 and around March 2018, with reference to orthodontic assessment, treatment planning and provision, a record of and report on radiographic findings, medical history, and informed consent. It is also alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of Patient 16, and that he inappropriately commenced treatment without having first secured the patient's periodontal health.

Patient 19

The heads of charge that Mr Hashmi faces in relation to Patient 19 are that he failed to maintain adequate records between 21 June 2017 and around March 2018, with regard to orthodontic assessment, treatment planning and provision, oral hygiene status, informed consent, the amount of IPR carried out and on which teeth, and details of enameloplasty provided in the patient's upper arch. It is also alleged that Mr Hashmi failed to carry out an adequate orthodontic assessment of the patient.

Patient 21

Mr Hashmi faces a number of allegations in respect of his care and treatment of Patient 21.

It is contended that, between 14 August 2017 and around November 2017, Mr Hashmi failed to maintain adequate records, with regard to the patient's dental history, evaluation, examination and charting, oral hygiene status, a record of and report on radiographic findings, discussions about treatment options, and the rationale for certain implant treatment.

It is also alleged that Mr Hashmi failed to carry out any, or any adequate, radiographic assessment of the proposed implant sites, and that he failed to carry out any, or any adequate, assessment of the patient's periodontal status. The GDC also contends that Mr Hashmi inappropriately placed only one implant in the patient's lower left quadrant, when two implants were indicated.

The GDC alleges that, in providing treatment to Patient 21, Mr Hashmi acted outside of the limits of his competence.

Patient 22

The GDC alleges that, in respect of Patient 22, Mr Hashmi failed to maintain adequate records between 21 December 2016 and 17 November 2017, with reference to the patient's medical and dental history, examinations and clinical evaluations, dental charting, oral hygiene status, diagnosis of periodontal disease, provision of treatment and a record of and report on radiographic findings.

It is also contended that, when discussing treatment options with the patient, Mr Hashmi inappropriately offered a partial chrome denture and root canal therapy (RCT) when neither were suitable for the patient.

Patient payments

As referred to above, Mr Hashmi faces allegations relating to payments made by patients for treatment. It is specifically alleged that, between the approximate dates of 29 July 2017 and 18 March 2018, Mr Hashmi obtained payments directly from patients in cash which he retained, and by transfer direct to his own personal bank account. It is alleged that Mr Hashmi concealed such payments from the practice, and also concealed from patients that their payments should not have been paid directly to him. The GDC contends that such alleged conduct was misleading and dishonest.

Advertising practices

Heads of charge in relation to Mr Hashmi's alleged advertising practices have also been raised against him.

On 22 January 2018 the GDC's Case Examiners (CEs) advised Mr Hashmi to ensure that his advertising was accurate with no potential to mislead, and did not permit any ambiguity about his training.

It is alleged that from around July 2018 Mr Hashmi advertised himself as an 'Experienced Cosmetic Dentist', and that he had obtained a Diploma in Facial Aesthetics. The GDC contends that no such dental qualification exists, and that Mr Hashmi's conduct was misleading and dishonest.

Indemnity insurance arrangements

The final area of concern for which heads of charge have been raised relates to Mr Hashmi's indemnity insurance arrangements.

It is alleged that Mr Hashmi failed to hold adequate indemnity insurance for the period of 10 February 2013 to around 21 January 2019. The GDC contends that such conduct was misleading and dishonest.

Evidence

The Committee heard oral evidence from the Clinical Director of the dental practice at which Mr Hashmi worked at the time of the alleged matters giving rise to these proceedings, who is referred to for the purposes of these proceedings as Witness A; from an expert witness instructed by the GDC in relation to the orthodontic treatment that Mr Hashmi provided, namely Mr Gerry Bellman; and from an expert witness also instructed by the GDC in respect of the implant treatment that Mr Hashmi provided, namely Professor Ian Brook. The Committee also listened to recordings of taped interviews conducted by the police with Mr Hashmi on 3 May 2018 in respect of the patient payment allegations.

The Committee has also been provided with documentary material in relation to the heads of charge that Mr Hashmi faces, including the witness statements and documentary exhibits of relevant witnesses put forward by the GDC, including those of Witness A and a number of the patients referred to above; the records of the 14 patients involved in this case; the expert reports of Mr Bellman and Professor Brook; Mr Hashmi's previous response to the allegations; Mr Hashmi's witness statements and documentary exhibits; the witness statements and documentary exhibits of witnesses put forward by Mr Hashmi; and the expert reports of two expert witnesses previously instructed by Mr Hashmi, namely Mr Christopher Holden and Mr Paul Craddock; and a case summary of the GDC's factual case.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both written and oral. It has considered the submissions made by Ms Barnfather on behalf of the GDC, and those made by Mr Serr prior to the withdrawal of Mr Hashmi and his legal representatives.

The Committee has accepted the advice of the Legal Adviser. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is to say, the balance of probabilities. The Committee has considered each head of charge separately, although some of its findings will be announced together.

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

1.	*Between April 2014 and 18 March 2018 you were in practice as an Associate at Practice 1 ('the Practice') (referred to in Schedule A).* **Proved**
	The Committee finds the facts alleged at head of charge 1 proved. The

	Committee notes that this is a head of charge raised by way of background, and that there is sufficient factual evidence contained in the bundle for the Committee to find the facts alleged at this uncontested head of charge proved.
2.	*You provided care and treatment under private contract to the patients set out in Schedule A.* **Proved**
	The Committee finds the facts alleged at head of charge 2 proved. The Committee finds that the documentary evidence presented to it demonstrates to the standard required that Mr Hashmi provided private care and treatment to the patients set out at Schedule A. The Committee also again notes that Mr Hashmi did not contest this charge when represented.
Patient 2	
3.	*You failed to maintain adequate records between 10 May 2017 and 26 February 2018 in that you did not record, adequately or at all:*
3. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 3 (a) not proved. The Committee finds at head of charge 4 below, which it considered before head of charge 3 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 2 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
3. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 3 (b) proved. The Committee finds from Mr Hashmi's records for Patient 2 that there are no entries in respect of a treatment plan or treatment objectives. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
3. c)	*oral hygiene status including a Periodontal Examination ('BPE');* **Proved**
	The Committee finds the facts alleged at head of charge 3 (c) proved. The Committee finds from Mr Hashmi's records for Patient 2 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE, save for a recorded request from the patient for a clean and

	polish. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
3. d)	*obtaining informed consent to:*
3. d) i)	*orthodontic treatment;* **Proved**
3. d) ii)	*Interproximal Reduction ("IPR")* **Proved**
	The Committee finds the facts alleged at heads of charge 3 (d) (i) and 3 (d) (ii) proved. The Committee finds that there is no information in the patient records setting out that informed consent was obtained in respect of orthodontic treatment and IPR. Although Mr Hashmi does not accept this head of charge in his witness statement, he stated that he has not documented his discussions with the patient about consent. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty.
3. e)	*the amount of IPR carried out and on which precise teeth;* **Proved**
	The Committee finds the facts alleged at head of charge 3 (e) proved. The Committee finds from Mr Hashmi's records for Patient 2 that there are no entries in respect of the amount of IPR carried out and on which teeth. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. The Committee also notes that Mr Holden agrees with Mr Bellman on this point. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
3. f)	*treatment provided at every appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 3 (f) proved. The Committee notes the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 2 attended with him were inadequate in that there are, in respect of some dates, no clinical notes made in respect of appointments that the patient attended. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.

4.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 4 proved. In approaching this head of charge the Committee notes the expert evidence of Mr Bellman about the features of a full orthodontic assessment, to include chief complaint, medical and dental history, habits, skeletal assessment, soft tissue assessment, intraoral assessment, oral hygiene, periodontal condition, caries, arch alignment, occlusion, diagnosis, treatment objectives and treatment plan. Mr Bellman also considers that the recording of an orthodontic assessment is a necessary part of such an assessment. The Committee accepts this evidence, and considers that Mr Hashmi was under a duty to conduct an adequate orthodontic assessment. The Committee notes from the records that Mr Hashmi made for Patient 2 that there are no entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. Mr Hashmi stated in his witness statement that at the first appointment with the patient on 10 May 2017 he believed he would have discussed with the patient the advantages and disadvantages of wearing fixed braces versus invisible aligners, and that he would keep a separate record of such assessments away from the main patient records. The Committee considers that discussing such advantages and disadvantages does not amount to an adequate orthodontic assessment. Indeed, the Committee notes that Mr Hashmi accepts this head of charge in his witness statement. The Committee also notes that the entry on 10 May 2017 does not contain relevant information about an orthodontic assessment, and that there are inadequate records of orthodontic assessments having been carried out at the subsequent appointments that followed. This is further suggestive of Mr Hashmi having failed in his duty to undertake an orthodontic assessment of the patient. For these reasons, the Committee finds the facts alleged at head of charge 4 proved.
Patient 3	
5.	*You failed to maintain adequate records between 11 December 2017 and about 5 March 2018 in that you did not record, adequately or at all:*
5. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 5 (a) not proved. The Committee finds at head of charge 6 below, which it considered before head of charge 5 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 3 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did

	not do.
5. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 5 (b) proved. The Committee finds from Mr Hashmi's records for Patient 3 that there are some brief entries which go towards a treatment plan or treatment objectives, but that these are not adequate records. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
5. c)	*oral hygiene status including a BPE;* **Proved**
	The Committee finds the facts alleged at head of charge 5 (c) proved. The Committee finds from Mr Hashmi's records for Patient 3 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
5. d)	*obtaining informed consent to orthodontic treatment;* **Not proved**
	The Committee finds the facts alleged at head of charge 5 (d) not proved. The Committee finds at head of charge 7 below, which it considered before head of charge 5 (d), that Mr Hashmi did not obtain informed consent for orthodontic treatment. As it has found that Mr Hashmi did not obtain informed consent, it follows that he could not record that which the Committee has found he did not do.
5. e)	*a record and/or report of findings in respect of undated radiographs including an OPG;* **Proved**
	The Committee finds the facts alleged at head of charge 5 (e) proved. The Committee finds from Mr Hashmi's records for Patient 3 that there are no entries setting out a record of or report on radiographs. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records and reports. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
5. f)	*treatment provided at every appointment;* **Proved**

	The Committee finds the facts alleged at head of charge 5 (f) proved. The Committee again notes the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 3 attended with him was inadequate. More particularly, there are, in respect of two dates, no clinical notes made in respect of the appointments that the patient attended on those dates. The Committee also notes from the witness statement of Patient 3 that the patient attended appointments on dates for which Mr Hashmi made no entries in the patient's notes. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
6.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 6 proved. In approaching this head of charge the Committee again accepts the expert evidence of Mr Bellman about the features of a 'full orthodontic assessment', and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 3 that there are no entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. This is suggestive of Mr Hashmi not having undertaken an orthodontic assessment of the patient. Indeed, the Committee notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 6 proved.
7.	*You failed to obtain informed consent to treatment in that Patient 3 was not adequately advised of the risks associated with her pre-existing root resorption.* **Proved**
	The Committee finds the facts alleged at head of charge 7 proved. The Committee notes that Mr Hashmi accepts this head of charge in his witness statement. There is no entry in the patient's clinical notes of informed consent or of the risks associated with treatment, and the Committee considers that it is reasonable to infer that informed consent was not obtained. The Committee also notes from the witness statement of Patient 3 that they did not have the risks of treatment explained to them. The Committee accepts the expert evidence of Mr Bellman that informed consent cannot be provided if the risks of treatment have not been

	properly explained. The patient's written evidence further suggests that informed consent was not, as Mr Hashmi accepts, obtained. The Committee also notes that a radiograph was not taken until the same day on which braces were fitted in February 2018. This suggests that an adequate period of time was not provided for the patient to provide informed consent in light of any risks and benefits of treatment identified on the radiograph. For these reasons, the Committee finds the facts alleged at head of charge 7 proved.
8.	*You inappropriately provided orthodontic treatment when Patient 3 was not a suitable candidate given root resorption at UL1-2 and UR1-2.* **Proved**
	The Committee finds the facts alleged at head of charge 8 proved. The Committee notes that in his witness statement Mr Hashmi accepted that Patient 3 was not a suitable candidate for orthodontic treatment. The Committee notes that in his expert evidence Mr Bellman stated that the radiographic evidence relating to this patient demonstrated that such orthodontic treatment should not have been provided given that there was pre-existing root resorption which meant that there was a likelihood of early loss of teeth arising from orthodontic treatment. The expert witness instructed by Mr Hashmi, namely Mr Christopher Holden, is of the same opinion.
9.	*Between 25 April 2018 and at least 24 March 2020 you failed to respond to communications from Patient 3's solicitors in connection with a potential claim against you for the orthodontic treatment you provided to Patient 3 between about January 2018 and March 2018.* **Proved**
	The Committee finds the facts alleged at head of charge 9 proved. The Committee notes from the documentary evidence presented to it that Mr Hashmi did not respond to the attempts to contact him beginning on 25 April 2018 made by the solicitors acting for Patient 3. These dates are itemised in the witness statement of the solicitor acting for Patient 3. The witness statement was unchallenged. The attempts included efforts to contact Mr Hashmi at a different practice and at his home address using multiple methods. The Committee considers that Mr Hashmi was under a duty to co-operate with such endeavours in accordance with the GDC's *Standards for the Dental Team.*
Patient 4	
10.	*You failed to maintain adequate records between 2 May 2017 and 14 March 2018 in that you did not record, adequately or at all:*
10. a)	*the patient's previous dental history;* **Proved**

	The Committee finds the facts alleged at head of charge 10 (a) proved. The Committee finds from Mr Hashmi's records for Patient 4 that there is a medical and dental history form dated 2 May 2017 which the patient completed. The Committee considers that there was therefore some dental history available to Mr Hashmi in the period of time specified in this head of charge. The patient's previous clinical records were also available to Mr Hashmi. Professor Brook stated in his evidence to the Committee that this dental history is inadequate, as there is no enquiry into factors that have resulted in decay, gum disease and loss of teeth. The Committee accepts the expert evidence of Professor Brook in this regard and finds that Mr Hashmi failed to make an adequate record of the patient's dental history. The Committee also notes that Mr Hashmi accepts this head of charge.
10. b)	*an examination of hard and/or soft tissues;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (b) proved. The Committee finds from Mr Hashmi's records for Patient 4 that on 7 June 2017 there is a reference to bone with a view to the placing of implants. On 21 July 2017 there is then a reference to '*healing well'* and the removal of sutures. These entries suggest that there was some recorded examination of hard and soft tissues. Professor Brook stated in his evidence to the Committee that a recorded examination of hard and soft tissues is missing. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make an adequate record of an examination of hard and soft tissues, and it considers that he did not do so adequately and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
10. c)	*dental charting;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (c) proved. The Committee finds from Mr Hashmi's records for Patient 4 that there is no reference to dental charting. Professor Brook stated in his evidence to the Committee that a chart or note of the teeth is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of dental charting, and it considers that he did not do so at all and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
10. d)	*oral hygiene status;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (d) proved. The Committee finds from Mr Hashmi's records for Patient 4 that there is no mention of the patient's oral hygiene status, save for the records containing

	a generic information sheet about hygiene maintenance. Professor Brook stated in his evidence to the Committee that a record of oral hygiene status is not present in the patient's records. The Committee accepts the expert evidence of Professor Brook, and indeed that of Mr Holden, that Mr Hashmi was under a duty to make a record of the patient's oral hygiene status. Professor Brook stated that doing so is important for the success of the treatment. The Committee considers that he did not do so at all, and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
10. e)	*a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (e) proved. The Committee finds from Mr Hashmi's records for Patient 4 that there is insufficient record of a clinical evaluation of height and/or width of proposed implant sites in the lower jaw. Professor Brook stated in his evidence to the Committee that a clinical evaluation of height and/or width of proposed implant sites in the lower jaw is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of such a clinical evaluation. Mr Holden states that the conducting of the CT scan as referred to in the patient's notes is likely to have meant that Mr Hashmi conducted a clinical evaluation. In any event, the Committee finds that Mr Hashmi did not record the evaluation adequately, and therefore failed in this duty.
10. f)	*a record and/or report of findings in respect of DPT radiographs taken on or about:*
10. f) i)	*21 June 2017;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (f) (i) proved. The Committee notes that in his evidence to the Committee Professor Brook stated that there is no record or report of findings arising out of a DPT radiograph taken on or about this date. The Committee agrees with Professor Brook's analysis, and further accepts his evidence that Mr Hashmi was under a duty to make such a record and report. The Committee notes that Mr Holden is of the same opinion. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee finds that Mr Hashmi failed in this duty, and it therefore finds the facts at this head of charge proved.
10. f) ii)	*14 March 2018;* **Proved**

	The Committee finds the facts alleged at head of charge 10 (f) (ii) proved. The Committee notes that in his evidence to the Committee Professor Brook stated that there is no record or report of findings arising out of a DPT radiograph taken on or about this date. The Committee agrees with Professor Brook's analysis, and further accepts his evidence that Mr Hashmi was under a duty to make such a record and report. The Committee notes that Mr Holden is of the same opinion. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee finds that Mr Hashmi failed in this duty, and it therefore finds the facts at this head of charge proved.
10. g)	*the provision of treatment on 21 June 2017 involving the placement of implants at LL3 and LR3;* **Not proved**
	The Committee finds the facts alleged at head of charge 10 (g) not proved, despite Mr Hashmi having accepted this head of charge in his witness statement. In his oral evidence to the Committee Professor Brook stated that on 21 June 2017 implant surgery took place, but that there is no record in the patient's notes relating to that surgery. The patient's records made by Mr Hashmi on 21 June 2017 states, *'NV – implant 2x lower to stabilise denture'*. This suggests that Mr Hashmi was intending to provide implant surgery on a later date. As stated above Professor Brook considers that in fact that the surgery was conducted on 21 June 2017, as sutures are recorded as having been removed at the next appointment one month later on 21 July 2017. In her witness statement Witness A identified two intervening appointments which took place on 26 June 2017 and 6 July 2017, for which entries were not made by Mr Hashmi in the patient's notes. Therefore the Committee was not able to identify the date on which the implants had been placed and whether the implants were placed on one of those two dates, or on 21 June 2017. As the Committee is not able to be satisfied that the placement of implants took place on 21 June 2017 as alleged, the Committee finds that the GDC has not demonstrated to the required standard that Mr Hashmi was under a duty to record that which the Committee cannot be satisfied he did. The Committee therefore finds the facts alleged at this head of charge not proved.
10. h)	*discussion with the patient regarding treatment options for the upper jaw including risks and benefits;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (h) proved. The Committee notes that Mr Hashmi accepted this head of charge in his

	witness statement. The Committee notes from Patient 4's records that Mr Hashmi made no entries at all concerning patient discussions regarding treatment options. The Committee notes the opinions of Professor Brook and Mr Holden that Mr Hashmi did not record patient discussions regarding treatment options, and that he should have done so. The Committee also notes the expert evidence of Mr Holden that Mr Hashmi made no entry in the patient's notes about a discussion with the patient regarding these matters. The Committee considers that Mr Hashmi failed in his duty to record any such discussions with the patient, and it therefore finds the facts alleged at this head of charge proved.
10. i)	*a diagnosis of periodontal disease and/or your rationale for the removal of the remaining teeth in the upper jaw on 30 October 2017;* **Proved**
	The Committee finds the facts alleged at head of charge 10 (i) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes from Patient 4's records that Mr Hashmi made no entries at all of a diagnosis of periodontal disease and/or his rationale for the removal of the remaining teeth in the upper jaw on 30 October 2017. The Committee also notes the expert evidence of Mr Holden that Mr Hashmi made no entry in the patient's notes of such a diagnosis and rationale. Professor Brook's evidence is that Mr Hashmi was under a duty to record his diagnosis and rationale. The Committee finds that Mr Hashmi failed in this duty, and it therefore finds the facts alleged at this head of charge proved.
10. j)	*a treatment plan involving the removal of upper teeth.* **Proved**
	The Committee finds the facts alleged at head of charge 10 (j) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes from Patient 4's records that Mr Hashmi made no entries at all of a treatment plan for the removal of upper teeth. The Committee also notes the expert evidence of Mr Holden that Mr Hashmi made no entry in the patient's notes of such a treatment plan. Professor Brook's evidence is that Mr Hashmi was under a duty to record a treatment plan involving the removal of upper teeth. The Committee finds that Mr Hashmi failed in this duty, and it therefore finds the facts alleged at this head of charge proved.
11.	*You placed implants at LL3 and LR3 which were angled divergently to each other rather than parallel.*

	Proved
	The Committee finds the facts alleged at head of charge 11 proved. The Committee notes that Mr Hashmi denies that he placed implants at the patient's LL3 and LR3 which were angled divergently to each other rather than parallel. Mr Hashmi stated that he *'would always use directional indicators'.* Professor Brook's evidence is that the aim should be to place implants parallel to each other rather than angled divergently. Professor Brook stated that the implants have been angled divergently at 15 degrees distally from the vertical plane. Mr Holden concurs with this assessment, but considers that it does not amount to a professional failing. The Committee has had regard to the patient's records and agrees that the two implants were angled divergently. The Committee therefore finds the facts alleged at this head of charge proved.
12.	*You failed:*
12. a)	*to adequately assess the patient prior to the placement of implants in the lower jaw;* **Not proved**
	The Committee finds the facts alleged at head of charge 12 (a) not proved. The Committee notes from the patient's records that Mr Hashmi placed two implants in the lower arch. Professor Brook's evidence to the Committee is that it appears from the patient's records that the implants were placed on 21 June 2017, although as stated above at head of charge 10 (g) there is some doubt about the accuracy of this particular date. As set out at head of charge 10 (g) above, it may be that the implants were in fact placed at one of two subsequent appointments on 26 June 2017 and 6 July 2017. In his expert report to the Committee Professor Brook states that there are a number of necessary components to a pre-implant assessment, namely the history of the condition, and the patient's needs and aspirations; previous dental history and other relevant clinical factors; medical and social history with evaluation as to any effect on treatment and periodontal health; clinical evaluation of the hard and soft tissues of the face and jaws, and of the dentition, periodontium and occlusion; dental charting; and periodontal and oral hygiene status and evaluation. The Committee has also had regard to the patient's records, and can see insufficient references to the aspects of a pre-treatment assessment identified by Professor Brook as being required. The entries that Mr Hashmi made in the patient's records include impressions, consent form, a discussion, costs, and the patient being advised that two implants would be needed. A CT scan was undertaken and reports from that scan stated the size of implants that would be required. Nonetheless, as stated above, these records do not demonstrate that an adequate assessment of the

	kind identified by Professor Brook took place. However, in this particular case the Committee is not content to infer from the shortcomings in the patient's records that Mr Hashmi did not conduct an adequate assessment in light of the evidence of Patient 4 and Mr Hashmi for the following reasons. The Committee has had regard to the evidence of the patient set out in her unchallenged witness statement. The Committee notes that the patient is unable to assist in relation to a pre-treatment assessment, and does not provide evidence to demonstrate that the assessment was inadequate. The patient stated in her unchallenged witness statement that Mr Hashmi discussed the shallow bone and a possible need for bone graft. In addition, Mr Hashmi discussed with the patient different denture options. This witness statement describes more activity than has been recorded in the patient's records. The Committee notes from his witness statement that Mr Hashmi maintains that he did conduct an adequate assessment of the patient. The Committee finds that in the circumstances the GDC has not adduced evidence sufficient to demonstrate that Mr Hashmi did not conduct an adequate pre-treatment assessment. The Committee therefore finds the facts alleged at this head of charge not proved.
12. b)	*to adequately plan the placement of implants in the lower jaw including with the use of stents or similar.* **Proved**
	The Committee finds the facts alleged at head of charge 12 (b) proved. In his expert report to the Committee Professor Brook stated that Mr Hashmi was under a duty to use a *'stent or other methods to ensure correct angulation of the implants'*. Professor Brook advocated the use of stents as *'a physical method of guiding implant placement'*. The Committee has found at head of charge 11 that the implants that Mr Hashmi placed were angled divergently to one another. Mr Brook is critical of Mr Hashmi's apparent omission of a stent or other methods and stated that use of such equipment could have avoided the divergent angulation. In his witness statement Mr Hashmi, in denying this allegation, did not say that he used a stent, but stated that he would *'always use directional indicators'* and '*would also use angled abutments if needed*'. Mr Holden's evidence is that this is an acceptable approach, although use of a stent might have assisted. Professor Brook's evidence is that directional indicators would be more appropriate for use by a more experienced practitioner. The Committee prefers and accepts the expert evidence of Professor Brook on the need for stents or similar. The Committee considers that Mr Hashmi should have used stents or similar as demonstrated by the

	outcome, namely divergent angulation of the implants. The Committee therefore finds the facts alleged at this head of charge proved.
13.	*In providing treatment to Patient 4 you acted outside the limits of your competence.* **Proved**
	The Committee finds the facts alleged at head of charge 13 proved. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. In his evidence to the Committee Professor Brook referred to the Faculty of General Dental Practitioners (FGDP) *Implant Training Standards* (2016) guidance which states that, *'before undertaking implant treatment, a dentist must develop competence in the procedures involved in clinical assessment, treatment planning, and the placement and restoration of implants. The skills and knowledge necessary for competence should be developed through a training course in implant dentistry, with a suitably trained and experienced clinician acting as a mentor'.* Professor Brook's evidence is that Mr Hashmi did not have the skills and knowledge necessary as identified by the FGDP. The Committee also notes that Mr Hashmi accepts this head of charge, stating that, *'with the benefit of hindsight I realise I was not adequately trained or mentored in the use of dental implants'.* Mr Holden agrees that Mr Hashmi would have acted outside of his competence if he did not have a mentor and had not had relevant training. Witness A's evidence is that she did not act as a mentor to Mr Hashmi in respect of implant practice, and did not provide training to him in implants. She also stated that she considered that providing supervision to Mr Hashmi in this regard would have been beyond her abilities. Witness A stated that she recommended to Mr Hashmi that he attend a hands-on course. The evidence provided to the Committee is that Mr Hashmi did not do so. In the circumstances the Committee considers that Mr Hashmi acted, as he accepts, outside the limits of his competence. The Committee therefore finds this head of charge proved.
Patient 5	
14.	*You failed to maintain adequate records between 17 July 2017 and about March 2018 in that you did not record, adequately or at all:*
14. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 14 (a) not proved. The Committee finds at head of charge 15 below, which it considered before head of charge 14 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 5 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did

	not do.
14. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 14 (b) proved. The Committee finds from Mr Hashmi's records for Patient 5 that there are some comments about treatment planning, but nothing to specify what the treatment plan was, or what the objectives were for treatment. The Committee finds that these are not adequate records. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
14. c)	*a report of findings in respect of an OPG recorded as having been taken on 8 August 2017;* **Proved**
	The Committee finds the facts alleged at head of charge 14 (c) proved. The Committee finds from Mr Hashmi's records for Patient 5 that there is no report on an OPG radiograph understood to have been taken on 8 August 2017. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such a report. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
14. d)	*obtaining informed consent to:*
14. d) i)	*orthodontic treatment;* **Proved**
14. d) ii)	*IPR;* **Proved**
	The Committee finds the facts alleged at heads of charge 14 (d) (i) and 14 (d) (ii) proved. The Committee notes that on 17 July 2017 Mr Hashmi made an entry in the patient's notes about treatment options, and that the patient wished to proceed with orthodontic treatment, but there was nothing recorded to suggest that she had been informed of the risks and benefits of orthodontic treatment to make an informed decision. The Committee can also see no entry in the patient's records to suggest that the patient provided their informed consent for IPR. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make adequate records of informed consent. As he did not do so adequately for orthodontic treatment, and at all for IPR, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts these heads of charge in his witness statement.
14. e)	*the amount of IPR carried out and on which precise teeth;*

	Proved
	The Committee finds the facts alleged at head of charge 14 (e) proved. The Committee finds from Mr Hashmi's records for Patient 5 that there are no entries in respect of the amount of IPR carried out and on which teeth. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
14. f)	*treatment provided at every appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 14 (f) proved. The Committee once more notes the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 5 attended with him were inadequate, in that there are no clinical notes made in respect of three appointments that the patient attended on those occasions. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
15.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 15 proved. In approaching this head of charge the Committee once more accepts the expert evidence of Mr Bellman about the features of a 'full orthodontic assessment', and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 5 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. Whilst there are some records about the patient's concerns, the patient's gum health and the patient's wishes, which suggests that there were some elements of an orthodontic assessment, the Committee considers that this does not amount to an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. The expert witness who provided a report for Mr Hashmi, namely Mr Holden, concurs that Mr Hashmi did not undertake an adequate orthodontic assessment. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 15 proved.

16.	*You inappropriately commenced orthodontic treatment without first securing Patient 5's periodontal health.* **Proved**
	The Committee finds the facts alleged at head of charge 16 proved. The Committee notes that in his witness statement Mr Hashmi accepted that he should have secured Patient 5's periodontal health before providing orthodontic treatment. The Committee notes that braces appear to have been fitted at the very same appointment at which Mr Hashmi conducted a BPE, meaning that insufficient time was allowed for periodontal treatment to take place before orthodontic treatment commenced. The BPE indicated that the patient required a scale and polish, and this was not acted upon as the braces were fitted the same day. The Committee notes that in his expert evidence Mr Bellman stated that Mr Hashmi should not have commenced orthodontic treatment until the patient's periodontal health had been secured. The Committee accepts this expert evidence, and considers that it was inappropriate for Mr Hashmi to have commenced orthodontic treatment in the circumstances.
Patient 6	
17.	*You failed to maintain adequate records between 2 August 2017 and about March 2018 in that you did not record, adequately or at all:*
17. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 17 (a) not proved. The Committee finds at head of charge 18 below, which it considered before head of charge 17 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 6 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
17. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 17 (b) proved. The Committee finds from Mr Hashmi's records for Patient 6 that there are some comments about the patient's objectives for treatment, but the Committee finds that these are not adequate records of treatment planning or treatment objectives prior to the fitting of the orthodontic appliance. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
17. c)	*oral hygiene status including BPE;*

	Proved
	The Committee finds the facts alleged at head of charge 17 (c) proved. The Committee finds from Mr Hashmi's records for Patient 6 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not make any such record, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
17. d)	*the taking of study models;* **Proved**
	The Committee finds the facts alleged at head of charge 17 (d) proved. The Committee can see no adequate entries in the patient records that Mr Hashmi made for Patient 6 concerning the taking of study models. There is a reference to the taking of impressions at one appointment, which might have been the first step in taking study models, but this entry is ambiguous. Mr Bellman in his expert evidence stated that he is critical of this omission, as they are *'essential to formulate a satisfactory treatment plan'*. The Committee considers that Mr Hashmi failed in his duty to make an adequate record of the taking of study models. The Committee also notes that in his witness statement Mr Hashmi accepted this head of charge.
17. e)	*obtaining informed consent to orthodontic treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 17 (e) proved. The Committee notes that there is a reference in the records that Mr Hashmi made for Patient 6, namely that verbal consent was given on 18 October 2017, but that this does not amount to an adequate record of informed consent, as there is no adequate itemisation of the necessary components of consent, including but not limited to risks and benefits, and treatment options. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make adequate records of informed consent. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.
17. f)	*treatment provided at every appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 17 (f) proved. The Committee again notes the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 6 attended with him were inadequate, in that there are no clinical notes made in respect of three appointments that the

	patient attended on those occasions. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
18.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 18 proved. In approaching this head of charge the Committee once more accepts the expert evidence of Mr Bellman about the features of a full orthodontic assessment, and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 6 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. This suggests that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 18 proved.
Patient 10	
19.	*You failed to maintain adequate records between 8 September 2017 and about March 2018 in that you did not record, adequately or at all:*
19. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 19 (a) not proved. The Committee finds at head of charge 20 below, which it considered before head of charge 19 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 10 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
19. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 19 (b) proved. The Committee finds from Mr Hashmi's records for Patient 10 that there are some limited comments about the patient's objectives for treatment and of there being a discussion about treatment, but the Committee finds that these are not adequate records of treatment planning or treatment objectives prior to the fitting of the orthodontic appliance. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under

	a duty to make such adequate records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
19. c)	*oral hygiene status including BPE;* **Proved**
	The Committee finds the facts alleged at head of charge 19 (c) proved. The Committee finds from Mr Hashmi's records for Patient 10 that there is a lack of entries in respect of the patient's oral hygiene status, for instance a record of a BPE, save for a reference to a visit on a later occasion to a dental hygienist. This reference to a dental hygienist does not amount to a record of the patient's oral hygiene status. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not make any records, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
19. d)	*the taking of study models;* **Proved**
	The Committee finds the facts alleged at head of charge 19 (d) proved. The Committee can see no adequate entries in the patient records that Mr Hashmi made for Patient 10 concerning the taking of study models. There is again a reference to the taking of impressions at one appointment, which might have been the first step in the production of study models, but this entry is not a clear record of the production of study models. The Committee again accepts the expert evidence of Mr Bellman of the need to record the taking of study models. The Committee considers that Mr Hashmi failed in his duty to make an adequate record of the taking of study models. The Committee also notes that in his witness statement Mr Hashmi accepted this head of charge.
19. e)	*obtaining informed consent to orthodontic treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 19 (e) proved. The Committee notes that there is a reference in the records that Mr Hashmi made in the patient records for Patient 10, namely that the patient wished to go ahead with treatment, but that this does not amount to an adequate record of informed consent, as there is no adequate itemisation of the necessary components of consent, including but not limited to risks and benefits, and treatment options. There is a subsequent reference in the patient records to consent on 27 September 2017, but this postdates the provision of treatment and in any event is not adequate. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make adequate records of informed consent. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.

19. f)	*treatment provided at every appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 19 (f) proved. The Committee has again had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 10 attended with him was inadequate, in that there are no clinical notes made in respect of five appointments that the patient attended on those dates. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
20.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 20 proved. In approaching this head of charge the Committee again accepts the expert evidence of Mr Bellman about the features of a 'full orthodontic assessment', and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 10 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. The entry that Mr Hashmi made in the patient's records on 8 September 2017 states that the patient was interested in orthodontic treatment, but there are no entries to suggest that an adequate orthodontic assessment was then undertaken. This suggests that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 20 proved.
Patient 11	
21.	*You failed to maintain adequate records between 7 December 2016 and 11 December 2017 in that you did not record, adequately or at all:*
21. a)	*the patient's previous dental history;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (a) proved. The Committee finds from Mr Hashmi's records for Patient 11 that there is a reference to the patient's presenting complaint at the appointment that took place with Mr Hashmi on 7 December 2016. The notes also refer to a discussion of treatment as having taken place in January 2017. There is

	also a medical and dental history form dated 2 May 2017 which the patient completed. Professor Brook stated in his evidence to the Committee that this dental history is inadequate, as there is no enquiry into factors that have resulted in decay, gum disease and loss of teeth. The Committee accepts the expert evidence of Professor Brook in this regard and finds that Mr Hashmi failed to make an adequate record of the patient's dental history. The Committee also notes that Mr Hashmi accepts this head of charge.
21. b)	*an examination of hard or soft tissues;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (b) proved. The Committee finds from Mr Hashmi's records for Patient 11 that on 10 February 2017 Mr Hashmi recorded that he had advised the patient that he would '*carry on for implant procedures, as soon as gum heals properly'.* The Committee considers that this is a reference to soft tissues, but does not amount to an adequate record of an examination of hard tissues. The Committee also notes that on 7 December 2016 Mr Hashmi made a reference to a BPE, which as Mr Holden suggests might entail a soft tissue examination, as well as nothing abnormal detected at soft tissues and at the temporomandibular joint on the left and right, but again the Committee does not consider that this amounts to an adequate record of a hard and soft tissue examination, as there is no reference to a hard tissue examination. Professor Brook stated in his evidence to the Committee that an examination of hard and soft tissues is missing. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make an adequate record of an examination of hard and soft tissues, and it considers that he did not do so adequately and therefore failed in this duty.
21. c)	*dental charting;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (c) proved. The Committee finds from Mr Hashmi's records for Patient 11 that there is no reference to dental charting. Professor Brook stated in his evidence to the Committee that a chart or note of the teeth is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of dental charting, and it considers that he did not do so at all and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
21. d)	*oral hygiene status;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (d) proved. The Committee finds from Mr Hashmi's records for Patient 11 that there is a reference to a BPE as recorded on 7 December 2016. This provides some

	limited information about the patient's oral hygiene status. Mr Holden's evidence is that this record can be relied on for the purposes of recording the patient's oral hygiene status. Professor Brook stated in his evidence to the Committee that this entry concerning BPE does not provide information about oral hygiene status. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of the patient's oral hygiene status, and considers that he failed to do so adequately as the entry concerning BPE does not provide information about oral hygiene status. The Committee therefore finds the facts alleged at this head of charge proved.
21. e)	*a diagnosis of chronic periodontal disease and/or your rationale for the removal of the remaining teeth in the lower jaw;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (e) proved. The Committee notes from Patient 11's records that Mr Hashmi made no entries at all of a diagnosis of periodontal disease and/or his rationale for the removal of the remaining teeth in the upper jaw. In his evidence to the Committee Professor Brook stated that, although Mr Hashmi recorded a BPE for the patient on 7 December 2016, this does not amount to a diagnosis of periodontal disease, and a BPE alone does not provide a rationale for removal of teeth. Mr Holden disagrees and considers that the recorded BPE was a sufficient basis upon which to predicate the removal of teeth. The Committee accepts and prefers the expert evidence of Professor Brook as being more credible on this point. The Committee considers that a BPE is not a proxy, as it were, for a diagnosis of periodontal disease and is not a sufficient rationale for the removal of teeth. The Committee finds that Mr Hashmi did not make any record of a diagnosis of periodontal disease, or a rationale for removal of teeth. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to do so, and that Mr Hashmi failed in this duty. The Committee therefore finds the facts alleged at this head of charge proved.
21. f)	*a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (f) proved. The Committee finds from Mr Hashmi's records for Patient 11 that there is no record of a clinical evaluation of height and/or width of proposed implant sites in the lower jaw. Professor Brook stated in his evidence to the Committee that a clinical evaluation of height and/or width of proposed implant sites in the lower jaw

	is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of such a clinical evaluation. Mr Holden agrees with Professor Brook that such a clinical evaluation was not recorded in the patient's notes, although there is a subsequent entry made in the patient's notes recording that previous unspecific entries had been deleted. The Committee finds that Mr Hashmi did not record the evaluation at all, and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
21. g)	*a record and/or report of findings in respect of:*
21. g) i)	*a DPT taken on 7 December 2017;* **Not proved**
21. g) ii)	*a CBCT taken on 13 March 2018;* **Not proved**
	The Committee finds the facts alleged at heads of charge 21 (g) (i) and 21 (g) (ii) not proved. The Committee has not been able to identify that the radiographs referred to in these heads of charge were in fact taken on the dates specified in these two heads of charge. The Committee considers that the GDC has not discharged its burden of proof on these heads of charge. Although Mr Hashmi has accepted heads of charge 21 (g) (i) and 21 (g) (ii), the Committee finds the facts alleged at these heads of charge not proved.
21. g) iii)	*two DPTs taken on 4 April 2017;* **Not proved**
	The Committee finds the facts alleged at head of charge 21 (g) (iii) not proved. The Committee notes from Patient 11's records that the patient attended an appointment with Witness A for sedation on 4 April 2017. There are five undated radiographs in the patient's records. The Committee notes that Professor Brook has attributed the date of 4 April 2017 to two of those radiographs on the basis that, in his view, surgery took place on that day. The patient's records are not sufficiently clear for the Committee to be satisfied that the radiographs were taken on the date alleged by the GDC, namely 4 April 2017. The Committee therefore finds that the GDC has not discharged its burden of proof on this head of charge. Although Mr Hashmi has accepted head of charge 21 (g) (iii), the Committee finds the facts alleged at this head of charge not proved.
21. g) iv)	*an undated DPT taken after the implants were uncovered;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (g) (iv) proved. The Committee notes that in his evidence to the Committee Professor Brook

	stated that there is no record or report of findings arising out of an undated DPT radiograph. There appear to be five undated radiographs contained in Patient 11's records. The Committee notes that Professor Brook notes that an undated and unnamed DPT radiograph was taken after the implants were exposed, or in other words uncovered. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make such a record and report, and it finds that he did neither at all. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee therefore finds the facts at this head of charge proved.
21. h)	*discussion with the patient regarding treatment options including risks and benefits;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (h) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes from Patient 11's records that Mr Hashmi made no entries at all concerning patient discussions regarding treatment options. The Committee notes that Mr Hashmi recorded on 18 January 2017 that he had a discussion with the patient about treatments. On 10 February 2017 Mr Hashmi recorded that he *'discussed in detail'* patient consent with the patient's husband. In his evidence to the Committee Mr Hashmi stated that Patient 11 had some issues with her memory, and that he would always explain relevant matters to her husband. The Committee notes the evidence of Professor Brook that Mr Hashmi did not properly record patient discussions regarding treatment options, and that he should have done so. The Committee considers that Mr Hashmi failed in his duty to record adequately such discussions with the patient, and it therefore finds the facts alleged at this head of charge proved.
21. i)	*a treatment plan involving the removal of lower teeth and implants at LL3 and LR3;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (i) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes from Patient 11's records that Mr Hashmi made no entries in respect of a treatment plan for the removal of lower teeth and the placing of implants at LL3 and LR3. The Committee again notes that Mr Hashmi recorded on 18 January 2017 that he had a discussion with the patient about treatments. On 10 February 2017 Mr Hashmi recorded that he '*discussed in detail'* patient consent with the patient's husband. As Professor Brook notes, there is no record of a treatment plan. The Committee agrees with Professor Brook in this regard.

	The Committee also again notes the expert evidence of Mr Holden that Mr Hashmi made no entry in the patient's notes of such a treatment plan, and that he should have done so. Professor Brook's evidence is that Mr Hashmi was under a duty to record a treatment plan involving the removal of lower teeth and placing of implants at LL3 and LR3. The Committee finds that Mr Hashmi failed in this duty by not making any records, and it therefore finds the facts alleged at this head of charge proved.
21. j)	*the provision of treatment between 13 March 2017 and 11 December 2017 involving:*
21. j) i)	*removal of lower teeth;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (j) (i) proved. The Committee notes from Patient's 11's records that there are no records relating to the removal of lower teeth at LL3 and LR3 between the dates specified, namely 13 March 2017 to 11 December 2017. Mr Holden also states that there is no record of such treatment, and that Mr Hashmi should have made such a record. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make such a record. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
21. j) ii)	*conversion of lower partial denture to a full denture;* **Proved**
	The Committee finds the facts alleged at head of charge 21 (j) (ii) proved. The Committee notes from Patient's 11's records that there are no records relating to the conversion of a lower partial denture to a full denture. Professor Brook considers that this was an omission on the part of Mr Hashmi. Mr Holden also states that there is no record of such treatment, and that Mr Hashmi should have made such a record. The Committee accepts the expert evidence of Mr Holden that Mr Hashmi was under a duty to make such a record. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
21. j) iii)	*the placement of implants at LL3 and LR3 on about 4 April 2017;* **Not proved**
	The Committee finds the facts alleged at head of charge 21 (j) (iii) not proved. The Committee notes from Patient's 11's records that on 18 April 2017 Mr Hashmi recorded that implants were placed at LR3 and LL3. It is also recorded on that date, *'previous notes deleted????'*. Professor Brook

	observes in his evidence that 'implants appear to have been placed under sedation on 4 April 2017 but the record of surgery is recorded on 18 April 2017'. Professor Brook in his oral evidence was critical of this entry not being marked as retrospective, as well as being critical of Mr Hashmi's apparent use of a template which related to upper arch rather than lower arch surgery. However, Professor Brook was not critical of the entry that Mr Hashmi made beyond those two reservations. Mr Holden is not critical, and considers that the entry that Mr Hashmi made was detailed, albeit it would have been helpful if Mr Hashmi would have marked the entry as retrospective. The Committee considers that the record that Mr Hashmi made, although not ideal, was adequate. The Committee therefore finds the facts alleged at head of charge 21 (j) (iii) not proved.
21. j) iv)	*further treatment at LR3 thereafter.* **Not proved**
	The Committee finds the facts alleged at head of charge 21 (j) (iv) not proved. Mr Hashmi stated in his witness statement that he cannot recall any further treatment being provided at Patient 11's LR3. The Committee again notes from Patient's 11's records that on 18 April 2017 Mr Hashmi recorded that implants were placed at LR3 and LL3. It is also recorded on that date, '*previous notes deleted????*'. Appointments are then recorded as having taken place on 10 May 2017, 24 May 2017, 24 July 2017, 24 November 2017 and 11 December 2017. At that final appointment on 11 December 2017 it is recorded that a radiograph would be taken of the implant at LR3 at the next appointment. Witness A recorded that she reviewed implants at the 24 July 2017 appointment. In his expert report Professor Brook stated that the implant at LR3 'took longer than LL3 to integrate, care being completed by a subsequent treating dentist. It is possible that the LR3 implant initially failed and was replaced'. The Committee has been provided with correspondence from a subsequent treating dentist about a lower-right implant, but the Committee is not satisfied that the GDC has demonstrated to the required standard that Mr Hashmi did in fact provide treatment to the LR3. Therefore, it follows that Mr Hashmi cannot be criticised for not recording treatment which the Committee is not satisfied he provided. The Committee accordingly finds the facts alleged at head of charge 21 (j) (iv) not proved.
22.	*You failed:*
22. a)	*to adequately assess the patient prior to the provision of implants;* **Proved**
	The Committee finds the facts alleged at head of charge 22 (a) proved. The Committee notes from his witness statement that Mr Hashmi accepts this head of charge.

	As set out at head of charge 12 (a) above, in his expert report to the Committee Professor Brook states that there are a number of necessary components to a pre-implant assessment, namely the history of the condition, and the patient's needs and aspirations; previous dental history and other relevant clinical factors; medical and social history with evaluation as to any effect on treatment and periodontal health; clinical evaluation of the hard and soft tissues of the face and jaws, and of the dentition, periodontium and occlusion; dental charting; and periodontal and oral hygiene status and evaluation. The Committee has also had regard to the patient's records, and can see some, but insufficient, references to the aspects of a pre-treatment assessment identified by Professor Brook as being required. The entries that Mr Hashmi made in the patient's records on 7 December 2016 include a reference to a BPE, nothing abnormal detected at soft tissues and at the temporomandibular joint on the left and right. Nonetheless, as stated above, these records do not demonstrate that an adequate assessment of the kind identified by Professor Brook took place. Taking into account that Mr Hashmi has stated in his witness statement that he did not undertake an adequate pre-treatment assessment, the Committee infers from the shortcomings in the patient's records that Mr Hashmi did not conduct an adequate assessment in light of the evidence of Patient 11. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to conduct such an adequate assessment, and having determined that Mr Hashmi did not do so adequately the Committee finds the facts alleged at this head of charge proved.
22. b)	*to adequately diagnose, adequately monitor and/or adequately treat periodontal disease prior to the provision of implants.* **Proved**
	The Committee finds the facts alleged at head of charge 22 (b) proved. As set out at head of charge 21 (d) above, the Committee notes from Patient 11's records that Mr Hashmi made no entries at all of a diagnosis of periodontal disease. He also made no entry to suggest that he treated that disease. In his witness statement Mr Hashmi accepted this head of charge and stated that the patient *'was not a suitable candidate for implants due to her periodontal condition'*. Again, as noted above at head of charge 21 (d) above, in his evidence to the Committee Professor Brook stated that, although Mr Hashmi recorded a BPE for the patient on 7 December 2016, this does not amount to a diagnosis of periodontal disease. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to diagnose, monitor and adequately treat periodontal disease prior to the placing of implants. Mr Holden agrees that Mr Hashmi was under a duty to do so, but did not state whether he

	considered that Mr Hashmi had or had not done so. The Committee infers from the absence of a record of a diagnosis, monitoring and treatment of periodontal disease that Mr Hashmi did not undertake such measures, and in so finding the Committee has had regard to Mr Hashmi's acceptance of the same. Having found that Mr Hashmi failed to adequately diagnose, monitor and adequately treat periodontal disease prior to the placing of implants, the Committee therefore finds the facts alleged at this head of charge proved.
23.	*You ought not to have placed implants at LR3 and LL3 as Patient 11 was not a suitable candidate for implants given her chronic periodontal disease.* **Proved**
	The Committee finds the facts alleged at head of charge 23 proved. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement, stating that the patient *'was not a suitable candidate for implants due to her periodontal condition'*. Professor Brook's evidence to the Committee is that Mr Hashmi could not have determined Patient 11's suitability for treatment without having provided periodontal care and monitoring oral hygiene beforehand. The Committee has found at the previous head of charge, namely head of charge 22 (b), that Mr Hashmi did not adequately diagnose, monitor and adequately treat periodontal disease prior to the placing of implants. The Committee accepts the expert evidence of Professor Brook on this point, and considers that Mr Hashmi should not have placed the implants referred to above. The Committee therefore finds the facts alleged at head of charge 23 proved.
Patient 12	
24.	*You failed to maintain adequate records between 18 April 2017 and 5 March 2018 in that you did not record, adequately or at all:*
24. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 24 (a) not proved. The Committee finds at head of charge 25 below, which it considered before head of charge 24 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 12 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
24. b)	*the treatment plan or objectives of treatment;* **Proved**

	The Committee finds the facts alleged at head of charge 24 (b) proved. The Committee finds from Mr Hashmi's records for Patient 12 that there are some references to treatment planning in the records relating to the appointment that took place on 10 May 2017, but this refers to what might happen at the next appointment, with the lower orthodontic appliance having been fitted at the appointment on 10 May 2017. This, in the Committee's view, does not amount to prior planning, and in turn means that the treatment planning was not carried out at all. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
24. c)	*a medical history;* **Proved**
	The Committee finds the facts alleged at head of charge 24 (c) proved. The Committee finds from Mr Hashmi's records for Patient 12 that on 18 April 2017 there is a recorded reference to an update to the medical history. There is also no medical history form within the patient's notes. The Committee considers that the records of medical history were not adequate. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. The Committee also notes the expert evidence of Mr Holden, who observes that there is no adequate medical history recorded by Mr Hashmi, and who agrees with Mr Bellman that a duty to record the same exists. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
24. d)	*A record and/or report of findings of an undated OPG;* **Prove**
	The Committee finds the facts alleged at head of charge 24 (d) proved. The Committee finds from Mr Hashmi's records for Patient 12 that there is no record of, or report on, an undated and unnamed OPG radiograph of which the Committee has had sight. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such a record and a report. As he did not make any record or report, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
24. e)	*the amount of IPR carried out and on which precise teeth;* **Proved**
	The Committee finds the facts alleged at head of charge 24 (e) proved. The Committee finds from Mr Hashmi's records for Patient 12 that there are insufficient entries in respect of the amount of IPR carried out and on which teeth. The Committee notes that Mr Hashmi made an entry on 27 July 2017 which stated, '*interproximal spacing lower anteriors'*. On 23 August 2017 there is an entry stating, '*IPR LR12'*. The Committee considers that these

	two entries do not represent an adequate record, as neither record the amount of IPR carried out, and the first entry does not identify the precise teeth. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records, and the Committee prefers his evidence in this respect over that of Mr Holden, whose evidence about the duty to record the amount of IPR and on which teeth is not consistent. As he did not do so, Mr Hashmi failed in this duty.
24. f)	*treatment provided at each appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 24 (f) proved. The Committee has again had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 12 attended with him was inadequate, in that there are no clinical notes made in respect of five appointments that the patient attended on those dates. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
25.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 25 proved. In approaching this head of charge the Committee once more accepts the expert evidence of Mr Bellman about the features of a full orthodontic assessment, and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 12 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. Although Mr Hashmi recorded a BPE on 18 April 2017, there are no further relevant entries. This suggests that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 25 proved.
26.	*You inappropriately commenced orthodontic treatment without first securing Patient 12's periodontal health.* **Proved**
	The Committee finds the facts alleged at head of charge 26 proved. The Committee notes that in his witness statement Mr Hashmi accepted

	that he should have carried out scaling for the patient prior to providing orthodontic treatment. The Committee notes that on 18 April 2017 Mr Hashmi recorded a BPE of '2's in all sextants. That record indicates that periodontal treatment was required to secure the patient's periodontal health. A lower orthodontic brace was subsequently fitted on 10 May 2017. After that date, a scaling was carried out, which postdates the treatment that Mr Hashmi provided to the patient. There is no record of any periodontal treatment, which was indicated by the BPE scores, having been carried out prior to the commencement of treatment. The Committee infers from this that Mr Hashmi did not carry out such periodontal treatment. The Committee notes that in his expert evidence Mr Bellman stated that Mr Hashmi should not have commenced orthodontic treatment until the patient's periodontal health had been secured. The Committee accepts this expert evidence, and finds that it was inappropriate of Mr Hashmi to have commenced orthodontic treatment in those circumstances.
Patient 13	
27.	*You failed to maintain adequate records between 29 September 2017 and about March 2018 in that you did not record, adequately or at all:*
27. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 27 (a) not proved. The Committee finds at head of charge 28 below, which it considered before head of charge 27 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 13 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
27. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 27 (b) proved. The Committee finds from Mr Hashmi's records for Patient 13 that there is a record of *'txt plan'*, presumably meaning treatment plan, at the appointment on 29 September 2017. This, in the Committee's view, does not amount to adequate planning. On 3 November 2017 there is reference to the patient needing two aligners, which suggests treatment objectives, but again this scant information is not adequate. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
27. c)	*oral hygiene status including BPE;*

	Proved
	The Committee finds the facts alleged at head of charge 27 (c) proved. The Committee finds from Mr Hashmi's records for Patient 13 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
27. d)	*the taking of study models;* **Proved**
	The Committee finds the facts alleged at head of charge 27 (d) proved. The Committee can see no adequate entries in the patient records that Mr Hashmi made for Patient 13 concerning the taking of study models. There is a reference to the taking of impressions at one appointment on 29 September 2017, which might have been the first step in taking study models, but this entry is not clear or specific. The Committee again accepts the expert evidence of Mr Bellman as to the need for study models. The Committee considers that Mr Hashmi failed in his duty to make an adequate record of the taking of study models. The Committee also notes that in his witness statement Mr Hashmi accepted this head of charge.
27. e)	*a medical history;* **Proved**
	The Committee finds the facts alleged at head of charge 27 (e) proved. The Committee finds from Mr Hashmi's records for Patient 13 that there is no record of a medical history having been taken at all. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
27. f)	*a record and/or report of findings of an undated OPG;* **Proved**
	The Committee finds the facts alleged at head of charge 27 (f) proved. The Committee finds from Mr Hashmi's records for Patient 13 that there is a reference to an undated OPG radiograph in the patient notes on 29 September 2017. This does not amount to an adequate record of the radiograph, and furthermore there is no report of findings. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such a record and a report. As he did not make an adequate record or any report, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
27. g)	*the amount of IPR carried out and on which precise teeth;*

	Proved
	The Committee finds the facts alleged at head of charge 27 (g) proved. The Committee finds from Mr Hashmi's records for Patient 13 that there are no entries in respect of the amount of IPR carried out and on which teeth. The Committee once more accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
27. h)	*treatment provided at each appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 27 (h) proved. The Committee has again had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 13 attended with him was inadequate, in that there are no clinical notes made in respect of six appointments that the patient attended on those dates. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
28.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 28 proved. In approaching this head of charge the Committee again accepts the expert evidence of Mr Bellman about the features of a full orthodontic assessment, and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 13 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. Although Mr Hashmi recorded *'ortho prelims'* on 29 September 2017, the Committee considers that this is not an adequate record of an orthodontic assessment, and further that it suggests that an adequate orthodontic assessment was not conducted. The Committee can also see no other or subsequent reference to an orthodontic assessment having been carried out. The Committee infers that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 28 proved.

29.	*You removed excessive enamel from:*
29. a)	*UL2;* **Proved**
	The Committee finds the facts alleged at head of charge 29 (a) proved. The Committee accepts the expert evidence of Mr Bellman that excess enamel was removed from the patient's UL2. Mr Holden's evidence is that there does not appear to have been an excessive removal of enamel at the tooth, although that there appears to have been an excessive enamel removal at a different tooth, namely UR2. However, having heard the evidence of Mr Bellman, the Committee accepts Mr Bellman's oral evidence that Mr Holden was likely to be referring to UL2 when referring to excess enamel removal, with the confusion arising as a result of the use of a mirror being used in the photograph that Mr Holden used to draw his conclusions.
29. b)	*LR1.* **Proved**
	The Committee finds the facts alleged at head of charge 29 (b) proved. The Committee notes from the patient's records that Patient 13 was unhappy with Mr Hashmi's treatment and that she went to a specialist orthodontist, who identified that there was a defect into dentine on the distal aspect *'which appears to have been caused by an interproximal stripping bur'*. Mr Bellman reviewed the patient records, which included the specialist orthodontist's view, and stated that in his opinion excessive enamel removal had occurred. The Committee accepts this expert evidence. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.
Patient 15	
30.	*You failed to maintain adequate records between 19 February 2018 and 14 March 2018 in that you did not record, adequately or at all:*
30. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 30 (a) not proved. The Committee finds at head of charge 31 below, which it considered before head of charge 30 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 15 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
30. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 30 (b) proved. The Committee finds from Mr Hashmi's records for Patient 15 that there is a

	record of a *'upper 2-2 misaligned'* on 19 February 2018. This, in the Committee's view, is merely an observation and does not amount to planning or identification of treatment objectives at all. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
30. c)	*oral hygiene status including BPE;* **Proved**
	The Committee finds the facts alleged at head of charge 30 (c) proved. The Committee finds from Mr Hashmi's records for Patient 15 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
30. d)	*treatment provided at each appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 30 (d) proved. The Committee has again had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 15 attended with him was inadequate, in that there are no clinical notes made in respect of one appointment that the patient attended on 13 March 2018. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
31.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 31 proved. In approaching this head of charge the Committee again accepts the expert evidence of Mr Bellman about the features of a full orthodontic assessment, and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 15 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. The Committee also notes from the patient's unchallenged witness statement stated that the patient did not have radiographs taken, which is further suggestive of an adequate orthodontic assessment not being done given that radiographs are an integral part of such an assessment. Although the Committee notes

	that there are, as Mr Bellman observes, past medical histories on record, as well as a brief record of misalignment at '*upper 2-2'*, the Committee considers that this is not an adequate record of an orthodontic assessment, and that this in turn it suggests that an adequate orthodontic assessment was not conducted. The Committee can also see no other or subsequent reference to an orthodontic assessment having been carried out. The Committee infers that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement, and notes that Mr Holden also considers that the orthodontic assessment was not adequate. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 31 proved.
32.	*You failed to obtain consent to treatment in that Patient 15 was not adequately advised of the outcome of treatment using only Quick Straight Teeth ('QST') appliances.* **Proved**
	The Committee finds the facts alleged at head of charge 32 proved. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. The Committee can see no reference in the patient's notes to suggest that informed consent was obtained for the QST treatment, including no reference to likely outcomes of treatment using QST appliances. The Committee infers from this absence that informed consent was not obtained. The Committee notes from the witness statement provided by the patient that there was some discussion about treatment options, but the Committee considers that this evidence does not suggest that there was an adequate discussion about the outcome of treatment using QST appliances. The Committee considers that a discussion of the outcome of treatment using QST appliances was a necessary precursor to, and integral component of, the obtaining of informed consent. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to obtain informed consent, and that he did not do so. The Committee also notes the evidence of Mr Holden that informed consent does not appear to have been obtained. As the Committee finds that Mr Hashmi failed in his duty to obtain informed consent, it finds the facts alleged at head of charge 32 proved.
33.	*You inappropriately provided two arch treatment with QST appliances when Patient 15 was not a suitable candidate given her complex malocclusion.* **Proved**
	The Committee finds the facts alleged at head of charge 33 proved. The Committee again notes that Mr Hashmi accepts this head of charge in

	his witness statement. In his evidence to the Committee Mr Bellman stated that as the patient had a class II division II malocclusion the proposed treatment was not appropriate given that complex malocclusion. The Committee also notes the evidence of Mr Holden, namely that he agrees with Mr Bellman's view. The Committee notes that in forming his opinion Mr Bellman had regard to a letter from a consultant orthodontist at Oxford University Hospitals who reviewed the patient at the request of Witness A following Mr Hashmi's treatment of the patient. That consultant orthodontist stated that Mr Hashmi's treatment was not appropriate given the patient's malocclusion.
34.	*In providing treatment to Patient 15 you acted outside the limits of your competence.* **Proved**
	The Committee finds the facts alleged at head of charge 34 proved. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. In his evidence to the Committee Mr Bellman stated that Patient 15 was not an appropriate candidate for the simple orthodontic treatment of QST, and should instead have been referred to a specialist orthodontist. The Committee notes the evidence of Mr Holden that the patient's presenting complex malocclusion would be a challenging case even for an experienced general dental practitioner, and should be referred to a specialist orthodontist. The Committee notes that, at the relevant time, Mr Hashmi had been qualified for four years. The Committee accepts this evidence, and considers that Mr Hashmi acted, as he accepts, outside the limits of his competence.
Patient 16	
35.	*You failed to maintain adequate records between 30 October 2017 and about March 2018 in that you did not record, adequately or at all:*
35. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 35 (a) not proved. The Committee finds at head of charge 36 below, which it considered before head of charge 35 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 16 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
35. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 35 (b) proved. The Committee finds from Mr Hashmi's records for Patient 16 that there are no records of any treatment plan or objectives of treatment. The Committee

	again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
35. c)	*a medical history;* **Not proved**
	The Committee finds the facts alleged at head of charge 35 (c) not proved. The Committee finds from Mr Hashmi's records for Patient 16 that there is a medical history form signed on 28 September 2017, which predates the date range with which this head of charge is concerned. The medical history was recorded as being updated by Mr Hashmi on 30 October 2017, which is within that date range. Mr Bellman stated in his evidence to the Committee that there is no medical history, but the Committee has had the benefit of the medical history before it. The Committee therefore finds that Mr Hashmi did in fact make an adequate record of the patient's medical history. The Committee therefore finds this head of charge not proved, despite Mr Hashmi's acceptance of the head of charge.
35. d)	*a record and/or report of findings of undated radiographs including an OPG;* **Proved**
	The Committee finds the facts alleged at head of charge 35 (d) proved. The Committee notes from Mr Hashmi's records for Patient 16 that there is an unnamed and undated OPG radiograph in the patient notes on 30 October 2017. The Committee notes that Mr Hashmi reported on the radiograph in terms of revealing the presence of caries detectable radiographically. This does not amount to an adequate record of or report on the radiograph as it does not include justification or grading. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such a record and a report. As he did not make an adequate record or adequate report, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
35. e)	*obtaining informed consent to orthodontic treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 35 (e) proved. The Committee notes that there is no adequate reference in the records that Mr Hashmi made in the patient records for Patient 16 regarding the obtaining of informed consent for orthodontic treatment. The Committee notes that there are some references to explaining the causes of bleeding gums as well as the appearance of decay at one tooth at the appointment on 30 October 2017, the discussion of which forms part of the consent process, but this does not amount to an adequate record of the obtaining of informed consent. The Committee notes the evidence of Mr Holden that informed consent was not properly recorded by Mr Hashmi in the patient's

	records. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make adequate records of informed consent. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.
35. f)	*treatment provided at each appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 35 (f) proved. The Committee has once more had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 16 attended with him was inadequate, in that there are no clinical notes made in respect of four appointments that the patient attended with Mr Hashmi. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
36.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 36 proved. In approaching this head of charge the Committee once more accepts the expert evidence of Mr Bellman about the features of a full orthodontic assessment, and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 16 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. Although Mr Hashmi recorded *'ortho prelims'* on 30 October 2017, the Committee considers that this is not an adequate record of an orthodontic assessment, and further that it suggests that an adequate orthodontic assessment was not conducted. The Committee can also see no other or subsequent reference to an orthodontic assessment having been carried out. The Committee infers that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 36 proved.
37.	*You inappropriately provided orthodontic treatment without first securing the Patient 16's periodontal health.* **Proved**

	The Committee finds the facts alleged at head of charge 37 proved. The Committee notes that in his witness statement Mr Hashmi accepted this head of charge. The Committee notes that on 30 October 2017 Mr Hashmi recorded a BPE of '2's in all sextants. On that same date Mr Hashmi recorded that he explained the causes of the bleeding gums about which the patient had complained, which suggests that Mr Hashmi gave some limited oral hygiene instructions. There is no record of any further or active periodontal treatment, which was indicated by the BPE scores, having been carried out prior to the commencement of treatment. The Committee infers from this that Mr Hashmi did not carry out such periodontal treatment, and that his giving of limited oral hygiene instructions was not sufficient in this regard. The Committee considers that periodontal treatment was required to secure the patient's periodontal health. Mr Holden's evidence is that Mr Hashmi should not have proceeded to provide orthodontic treatment given what he considers is the presence of gingivitis as suggested by the BPE scores referred to above. The Committee also notes that in his expert evidence Mr Bellman stated that Mr Hashmi should not have commenced orthodontic treatment until the patient's periodontal health had been secured. The Committee accepts this expert evidence, and finds that it was inappropriate of Mr Hashmi to have commenced orthodontic treatment in those circumstances.
Patient 19	
38.	*You failed to maintain adequate records between a date prior to 21 June 2017 and about March 2018 in that you did not record, adequately or at all:*
38. a)	*a comprehensive orthodontic assessment;* **Not proved**
	The Committee finds the facts alleged at head of charge 38 (a) not proved. The Committee finds at head of charge 39 below, which it considered before head of charge 38 (a), that Mr Hashmi did not carry out an adequate orthodontic assessment. The Committee finds that the records for Patient 19 do not contain a comprehensive orthodontic assessment. As it has found that Mr Hashmi did not carry out an adequate orthodontic assessment, it follows that he could not record that which the Committee has found he did not do.
38. b)	*the treatment plan or objectives of treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 38 (b) proved. On 21 June 2017 Mr Hashmi stated in the patient's records that the patient *'wants upper and lower'*. There is also reference on that same date to the patient being aware that alignment would take place with QST appliances. The Committee considers that these are inadequate records in respect of a treatment plan or objectives of treatment. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make

	such records. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
38. c)	*oral hygiene status including BPE;* **Proved**
	The Committee finds the facts alleged at head of charge 38 (c) proved. The Committee finds from Mr Hashmi's records for Patient 19 that there are no entries in respect of the patient's oral hygiene status, for instance a record of a BPE. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
38. d)	*obtaining informed consent to:*
38. d) i)	*orthodontic treatment;* **Proved**
	The Committee finds the facts alleged at head of charge 38 (d) (i) proved. The Committee notes that there is no adequate reference in the records that Mr Hashmi made in the patient records for Patient 19 regarding the obtaining of informed consent for orthodontic treatment. The Committee notes that there is no consent form contained in the patient's records. The Committee notes that there is a recorded reference to the patient's desire for orthodontic appliances on 21 June 2017, the discussion of which forms part of the consent process, but this does not amount to an adequate record of the obtaining of informed consent. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make adequate records of informed consent. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.
38. d) ii)	*IPR;* **Proved**
	The Committee finds the facts alleged at head of charge 38 (d) (ii) proved. The Committee notes that there is no adequate reference in the records that Mr Hashmi made for Patient 19 regarding the obtaining of informed consent for IPR. The Committee notes that there is no consent form contained in the patient's records. The Committee also notes that there is a recorded reference to *'interproximal spacing'* on 23 August 2017, but this does not amount to a record of the obtaining of informed consent for IPR. The Committee accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make records of informed consent. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge in his witness statement.

38. e)	*the amount of IPR carried out and on which precise teeth;* **Proved**
	The Committee finds the facts alleged at head of charge 38 (e) proved. The Committee finds from Mr Hashmi's records for Patient 19 that there are no adequate entries in respect of the amount of IPR carried out and on which teeth. The Committee notes a limited reference that Mr Hashmi made on 23 August 2017 to '*interproximal spacing uppers/lowers anteriors'*. This in the Committee's view does not amount to a record of the amount of IPR carried out and on which precise teeth, as the precise teeth and amount of IPR carried out are not recorded. The Committee once more accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such adequate records. As he did not do so at all, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
38. f)	*the details of enameloplasty provided in the upper arch;* **Not proved**
	The Committee finds the facts alleged at head of charge 38 (f) not proved. The Committee notes from Mr Hashmi's records for Patient 19 there is reference to upper enameloplasty on 13 September 2017. The Committee can find no reference to any criticisms of Mr Hashmi's practice in this regard in Mr Bellman's evidence. The Committee notes that Mr Holden in his report states that Mr Hashmi made the entry referred to above, but that Mr Hashmi did not record details. The Committee considers that the GDC has not adduced sufficient evidence to demonstrate that Mr Hashmi was under a duty to record the details of enameloplasty. Although the Committee notes that Mr Hashmi accepts this head of charge, the Committee considers that there is insufficient evidence for the charge to be found proved. It therefore finds that the head of charge is not proved.
38. g)	*treatment provided at each appointment.* **Proved**
	The Committee finds the facts alleged at head of charge 38 (g) proved. The Committee has once more had regard to the evidence of Witness A that a separate record of the dates of specific appointments can be compared with a clinician's records. The Committee has had regard to Mr Hashmi's patient records and considers that his records of treatment provided at the appointments that Patient 19 attended with him was inadequate, in that there are no clinical notes made in respect of seven appointments that the patient attended with Mr Hashmi. The Committee again accepts the expert evidence of Mr Bellman that Mr Hashmi was under a duty to make such records. As he did not do so, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.

39.	*You failed to carry out an adequate orthodontic assessment.* **Proved**
	The Committee finds the facts alleged at head of charge 39 proved. In approaching this head of charge the Committee again accepts the expert evidence of Mr Bellman about the features of a 'full orthodontic assessment', and of the duty to perform such an assessment. The Committee notes from the records that Mr Hashmi made for Patient 19 that there is a lack of entries concerning orthodontic assessment at the appointments that the patient attended with Mr Hashmi. At the fitting appointment on 21 June 2017 it is recorded that the notes relating to previous notes and consultations having been deleted. The Committee considers that there is not an adequate record of an orthodontic assessment, and further that it suggests that an adequate orthodontic assessment was not conducted. The Committee can also see no other or subsequent reference to an orthodontic assessment having been carried out. The Committee infers that Mr Hashmi did not undertake an adequate orthodontic assessment of the patient. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. For these reasons, the Committee finds that Mr Hashmi failed in his duty to conduct an adequate orthodontic assessment. Therefore, the Committee finds the facts alleged at head of charge 39 proved.
Patient 21	
40.	*You failed to maintain adequate records between 14 August 2017 and about November 2017 in that you did not record, adequately or at all:*
40. a)	*the patient's previous dental history;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (a) proved. The Committee finds from Mr Hashmi's records for Patient 21 that there is a reference to the patient's presenting complaint at the appointment that took place with Mr Hashmi on 27 September 2017. The notes also refer to a discussion of treatment as having taken place in January 2017. There is also a medical and dental history form dated 14 January 2017 which the patient completed. The Committee has again had regard to the expert evidence of Professor Brook, who stated that Mr Hashmi's recording of the dental history is missing, as there is no enquiry into factors that have resulted in decay, gum disease and loss of teeth. Mr Holden is also critical of Mr Hashmi's omission. The Committee accepts the expert evidence of Professor Brook in this regard and finds that Mr Hashmi failed to make any record of the patient's dental history. The Committee also notes that Mr Hashmi accepts this head of charge.
40. b)	*an examination of hard or soft tissues;*

	Proved
	The Committee finds the facts alleged at head of charge 40 (b) proved. The Committee notes that Mr Hashmi accepts this head of charge. The Committee can find no record in Mr Hashmi's records for Patient 21 of an examination of hard and soft tissues. Professor Brook stated in his evidence to the Committee that an examination of hard and soft tissues is missing. Mr Holden concurs with Professor Brook's assessment. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make an adequate record of an examination of hard and soft tissues, and it considers that he did not do so at all and therefore failed in this duty.
40. c)	*dental charting;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (c) proved. The Committee finds from Mr Hashmi's records for Patient 21 that there is no reference to dental charting. The Committee again accepts the expert evidence of Professor Brook, namely that a chart or note of the teeth is missing from the patient's records. The Committee also notes that Mr Holden agrees that Mr Hashmi did not make a record of dental charting. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make a record of dental charting, and it considers that he did not do so at all and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
40. d)	*oral hygiene status;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (d) proved. The Committee again notes that Mr Hashmi accepts this head of charge. The Committee finds from Mr Hashmi's records for Patient 21 that there is no reference to the patient's oral hygiene status. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi did not record the oral hygiene status of Patient 21. Mr Holden agrees with his assessment. The Committee also accepts Professor Brook's evidence that Mr Hashmi was under a duty to make a record of the patient's oral hygiene status. The Committee considers that Mr Hashmi failed to do so at all. The Committee therefore finds the facts alleged at this head of charge proved.
40. e)	*a clinical evaluation of height and/or width of proposed implant site or sites in the lower arch;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (e) proved. The Committee again notes that Mr Hashmi accepts this head of charge. The Committee finds from Mr Hashmi's records for Patient 21 that there is no

	record of a clinical evaluation of height and/or width of proposed implant site or sites in the lower arch. Professor Brook stated in his evidence to the Committee that a clinical evaluation of height and/or width of proposed implant sites in the lower jaw is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of such a clinical evaluation. Mr Holden agrees that Mr Hashmi did not make a record of a clinical evaluation. The Committee finds that Mr Hashmi did not record the evaluation at all, and therefore failed in this duty.
40. f)	*record and/or report of findings in respect of:*
40. f) i)	*any pre-operative DPT radiographs;* **Not proved**
	The Committee finds the facts alleged at head of charge 40 (f) (i) not proved. The Committee notes that Mr Hashmi accepts this head of charge in his witness statement. The Committee has not been able to identify a preoperative DPT radiograph from the records that Mr Hashmi made for Patient 21. The Committee is therefore not able to be satisfied that Mr Hashmi was under a duty to record and report on the findings of a radiograph which does not appear to exist. The Committee considers that the GDC has not discharged its burden of proof on this head of charge, and it therefore finds the facts alleged at head of charge 40 (f) (i) not proved, despite Mr Hashmi having accepted it in his witness statement.
40. f. ii)	*a post-operative DPT taken on 27 September 2017;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (f) (ii) proved. The Committee notes that in his evidence to the Committee Professor Brook stated that there is no record or report of findings arising out of a postoperative DPT radiograph taken on 27 September 2017. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make such a record and report, and it finds that he did neither at all. Mr Holden's evidence is similarly that there is no report or grading of the radiograph. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee therefore finds the facts at this head of charge proved.
40. f. iii)	*a PA radiograph taken on 27 September 2017;* **Proved regarding report**
	The Committee finds the facts alleged at head of charge 40 (f) (iii) proved regarding a report. The Committee notes that in his evidence to the Committee Professor Brook

	stated that there is no record or report of findings arising out of a periapical radiograph taken on 27 September 2017. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make such a record and report, and it finds that he did not make any report, but did make a record of it in the patient's notes. Mr Holden's evidence is similarly that there is no report or grading of the radiograph. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee therefore finds the facts at this head of charge proved to the extent of there being no report.
40. g)	*discussion with the patient regarding treatment options including risks and benefits;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (g) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee considers from Patient 21's records that Mr Hashmi made no entries at all concerning patient discussions regarding treatment options. The Committee notes the evidence of Professor Brook that Mr Hashmi did not properly record patient discussions regarding treatment options, and that he should have done so. The Committee also notes the evidence of Mr Holden that there is no record of a discussion of options, risks and benefits with the patient. Mr Holden identified the risks that the treatment posed. The Committee considers that Mr Hashmi failed in his duty to record adequately such discussions with the patient, and it therefore finds the facts alleged at this head of charge proved.
40. h)	*a treatment plan involving an implant at LL4;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (h) proved. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes from Patient 21's records that Mr Hashmi made no entries in respect of a treatment plan involving the placing of an implant at the patient's LL4. Professor Brook is critical of this omission. The Committee also again notes the expert evidence of Mr Holden that if Mr Hashmi provided a treatment plan to the patient he should have retained a copy of the same in the patient's records. Professor Brook's evidence is that Mr Hashmi was under a duty to record a treatment plan involving an implant at LL4. The Committee finds that Mr Hashmi failed in this duty by not making any such records, and it therefore finds the facts alleged at this head of charge proved.

40. i)	*the provision of treatment involving the placement of an implant at LL4 on 27 September 2017;* **Proved**
	The Committee finds the facts alleged at head of charge 40 (i) proved. The Committee notes from Patient's 21's records that there is some limited information relating to the placement of an implant at LL4 on 27 September 2017. Professor Brook and Mr Holden are both critical of shortcomings in this record, with particular reference to details relating to the bone graft. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make such a record. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
40. j)	*the rationale for the placement on one implant only on 27 September 2017 when a second implant was required for an implant retained bridge at LL4-LL7.* **Proved**
	The Committee finds the facts alleged at head of charge 40 (j) proved. The Committee notes from his witness statement that Mr Hashmi accepts this head of charge. The Committee notes from Patient's 21's records that there is some limited information relating to the placement of an implant at LL4 on 27 September 2017. Professor Brook's evidence is that a second implant which was required should have been placed at the same appointment to reduce patient morbidity, and that if there had been good reason for not doing so Mr Hashmi should have recorded such a rationale. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make such a record of any such rationale. The Committee also notes that Mr Holden is of the same opinion. As he did not do so at all, Mr Hashmi failed in this duty.
41.	*You failed:*
41. a)	*to carry out any, or any adequate, radiographic assessment of the proposed implant site or sites;* **Proved**
	The Committee finds the facts alleged at head of charge 41 (a) proved. The Committee has determined above at head of charge 40 (f) (i) that a preoperative DPT radiograph does not appear to have been taken. Mr Hashmi's evidence is that he cannot state with certainty whether he took preoperative radiographs, although he states that it was his usual practice to do so. Mr Hashmi accepts the allegation at this head of charge. Professor Brook's evidence is that preoperative radiographs, and at least a DPT, should have been taken. Mr Holden's evidence is that he cannot

	state whether radiographs were taken, and is critical of the omission of radiographs if in fact Mr Hashmi did not take them. The Committee finds on balance, and again noting Mr Hashmi's acceptance, that Mr Hashmi did not carry out any preoperative radiographic assessment, as it infers from the absence of any such radiographs, and the absence of a report or record of such radiographs, that no such radiographs were taken. The Committee therefore finds the facts alleged at this head of charge proved.
41. b)	*to carry out any, or any adequate, assessment of the patient's periodontal status.* **Proved**
	The Committee finds the facts alleged at head of charge 41 (b) proved. The Committee notes that Mr Hashmi accepts this head of charge in his witness statement. Professor Brook's evidence is that the failure of Patient 21's implant was in part due to Mr Hashmi's inadequate assessment and treatment of the patient's periodontal status. More particularly, the patient's smoking habits and pre-existing gingivitis should have been considered and mitigated at the planning stage of care. Mr Holden's evidence is that Mr Hashmi made no record of a BPE and no recorded monitoring of periodontal health. Mr Holden's evidence is that if such assessments did take place then the implant treatment would have been contraindicated. As set out at head of charge 40 (d) above, the Committee notes from Patient 21's records that Mr Hashmi made no entries at all of an assessment of the patient's periodontal status. The Committee infers from this, and taking account of his acceptance, that Mr Hashmi did not conduct such an assessment at all. The Committee therefore finds the facts alleged at this head of charge proved.
42.	*You inappropriately placed only one implant in the lower left quadrant on 27 September 2017 when two were indicated to achieve long term retention of the planned implant supported bridge at LL4-LL6.* **Proved**
	The Committee finds the facts alleged at head of charge 42 proved. The Committee notes from his witness statement that Mr Hashmi accepts this head of charge. The Committee notes from Patient's 21's records that on 27 September 2017 Mr Hashmi placed a single implant at LL4. As set out at head of charge 40 (j) above Professor Brook's evidence is that a second implant which was required should have been placed at the same appointment to reduce patient morbidity. Professor Brook states that two implants were indicated to achieve long-term retention of the planned implant-supported

	bridge spanning LL4 to LL6. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi should have placed two, rather than just one, implants at the appointment that took place on 27 September 2017. The Committee considers that it was inappropriate for Mr Hashmi to place a single implant when two were indeed needed and could have been provided on that same day. The Committee therefore finds the facts alleged at this head of charge proved.
43.	*In providing treatment to Patient 21 you acted outside the limits of your competence.* **Proved**
	The Committee finds the facts alleged at head of charge 43 proved. The Committee again notes that Mr Hashmi accepts this head of charge in his witness statement. The Committee once more notes that, in his evidence to the Committee, Professor Brook referred to the Faculty of General Dental Practitioners (FGDP) *Implant Training Standards* (2016) guidance which states that, 'before undertaking implant treatment, a dentist must develop competence in the procedures involved in clinical assessment, treatment planning, and the placement and restoration of implants. The skills and knowledge necessary for competence should be developed through a training course in implant dentistry, with a suitably trained and experienced clinician acting as a mentor'. Professor Brook's evidence is that Mr Hashmi did not have the skills and knowledge necessary as identified by the FGDP. Mr Holden agrees that Mr Hashmi would have acted outside of his competence if he did not have a mentor and had not had relevant training. Witness A's evidence is, again, is that she did not act as a mentor to Mr Hashmi in respect of implant practice, and did not provide training to him in implants. She also stated that she considered that providing supervision to Mr Hashmi in this regard would have been beyond her abilities. Witness A stated that she recommended to Mr Hashmi attend a hands-on course. The evidence provided to the Committee is that Mr Hashmi did not do so. In the circumstances the Committee considers that Mr Hashmi acted, as he accepts, outside the limits of his competence. The Committee therefore finds this head of charge proved.
Patient 22	
44.	*You failed to maintain adequate records between 21 December 2016 and 17 November 2017 in that you did not record, adequately or at all:*
44. a)	*the patient's previous medical history;* **Not proved**

	The Committee finds the facts alleged at head of charge 44 (a) not proved. The Committee finds from Mr Hashmi's records for Patient 22 that there is a medical and dental history form dated 29 November 2016 which the patient completed. This would have been available to Mr Hashmi. There is also a record of the patient's medical history having been checked on 15 February 2017 and 25 August 2017. The Committee has again had regard to the expert evidence of Professor Brook, who stated that Mr Hashmi's recording of the medical history is missing. Mr Holden is also critical of Mr Hashmi's omission. However, the Committee notes that both expert witnesses suggest that a medical history form was not present, whereas the Committee has been provided with such a form. As both experts predicate their criticisms of Mr Hashmi on the absence of this form, the Committee finds the facts alleged at this head of charge not proved, notwithstanding the acceptance of the head of charge in Mr Hashmi's witness statement.
44. b)	*the patient's previous dental history;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (b) proved. The Committee again notes from Mr Hashmi's records for Patient 22 that there is a medical and dental history form dated 29 November 2016 which the patient completed. This would have been available to Mr Hashmi. The Committee has again had regard to the expert evidence of Professor Brook, who stated that Mr Hashmi's recording of the patient's dental history is missing. Mr Holden is also critical of Mr Hashmi's omissions. The Committee considers that the records that Mr Hashmi made of the patient's dental history in the patient's notes is inadequate. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of the patient's dental history, and that he did not do so adequately. The Committee also notes that Mr Hashmi accepts this head of charge.
44. c)	*an examination of hard or soft tissues;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (c) proved. The Committee notes that Mr Hashmi accepts this head of charge. The Committee notes from Mr Hashmi's records for Patient 22 that on 27 February 2017 and 5 September 2017 Mr Hashmi made references to the patient's gums, which is soft tissue. Professor Brook stated in his evidence to the Committee that an examination of hard and soft tissues is missing. Mr Holden concurs with Professor Brook's assessment. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make an adequate record of an examination of hard and soft tissues. The Committee considers

	that Mr Hashmi did not do so adequately and therefore failed in this duty.
44. d)	*dental charting;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (d) proved. The Committee finds from Mr Hashmi's records for Patient 22 that there is no reference to dental charting. The Committee again accepts the expert evidence of Professor Brook, namely that a chart or note of the teeth is missing from the patient's records. The Committee also notes that Mr Holden agrees that Mr Hashmi did not make a record of dental charting. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make a record of dental charting, and it considers that he did not do so at all and therefore failed in this duty. The Committee also notes that Mr Hashmi accepts this head of charge.
44. e)	*oral hygiene status;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (e) proved. The Committee again notes that Mr Hashmi accepts this head of charge. The Committee finds from Mr Hashmi's records for Patient 22 that there is no reference to the patient's oral hygiene status. The Committee again accepts the expert evidence of Professor Brook that Mr Hashmi did not record the oral hygiene status of Patient 22. The Committee also accepts Professor Brook's evidence that Mr Hashmi was under a duty to make a record of the patient's oral hygiene status. Mr Holden once more agrees with Professor Brook's view. The Committee therefore finds the facts alleged at this head of charge proved.
44. f)	*a diagnosis of periodontal disease and/or your rationale for the removal of the remaining teeth in the upper and lower jaws;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (f) proved. The Committee notes that Mr Hashmi accepts this head of charge in his witness statement. The Committee notes from Patient 22's records that Mr Hashmi made no entries at all of a diagnosis of periodontal disease and/or his rationale for the removal of the remaining teeth in the upper and lower jaws. In his evidence to the Committee Professor Brook stated that Mr Hashmi did not record a diagnosis of periodontal disease or record a rationale for removal of teeth. Mr Holden is of the same view. The Committee finds that Mr Hashmi did not make any record of a diagnosis of periodontal disease, or a rationale for removal of teeth. The

	Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to do so, and finds that Mr Hashmi failed in this duty as he did not make any such entries. The Committee therefore finds the facts alleged at this head of charge proved.
44. g)	*a clinical evaluation of height and/or width of proposed implant sites in the lower jaw;* **Proved**
	The Committee finds the facts alleged at head of charge 44 (g) proved. The Committee again notes that Mr Hashmi accepts this head of charge. The Committee finds from Mr Hashmi's records for Patient 22 that there is no record of a clinical evaluation of height and/or width of proposed implant sites in the lower jaw. Professor Brook stated in his evidence to the Committee that a clinical evaluation of height and/or width of proposed implant sites in the lower jaw is missing from the patient's records. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of such a clinical evaluation. Mr Holden agrees that Mr Hashmi did not make a record of a clinical evaluation. The Committee finds that Mr Hashmi did not record an evaluation at all, and therefore failed in this duty.
44. h)	*a record and/or report of findings in respect of:*
44. h) i)	*a DPT taken on 21 December 2016;* **Proved in respect of a report**
	The Committee finds the facts alleged at head of charge 44 (h) (i) proved in respect of a report. The Committee notes that in his evidence to the Committee Professor Brook stated that there is no record or report of findings arising out of a DPT radiograph taken on 21 December 2016. There is reference to an OPG in the patient's notes on that date, but the Committee can see no report on the same. The Committee notes Professor Brook's evidence that Mr Hashmi was under a duty to make a report and did not do so. Mr Holden's evidence is similarly that there is no report or grading of the radiograph. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee finds the facts at this head of charge proved to the extent of there being no report.
44. h) ii)	*PA radiographs and a DPT taken on 25 August 2017* **Proved regarding no report on the periapical radiographs and no record of, or report on, the DPT radiograph.**
	The Committee finds the facts alleged at head of charge 44 (h) (ii) proved regarding no report on the periapical radiographs and no record of, or report on, the DPT radiograph. The Committee notes from the patient's notes that there is no record or report of findings arising out of a DPT radiograph taken on 25 August 2017.

	There is a record of periapical radiographs being taken, but there is no report on those radiographs. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make such a record and report in respect of all of the radiographs. The Committee finds that there is no report on the periapical radiographs and no record of, or report on, the DPT radiograph. Mr Holden's evidence is similarly that there is no report or grading of the radiographs. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee therefore finds the facts at this head of charge proved to the extent of there being no report on the periapical radiographs and no record of, or report on, the DPT radiograph.
44. h) iii)	*a CBCT dated 13 June 2017;* **Proved in respect of a report**
	The Committee finds the facts alleged at head of charge 44 (h) (iii) proved. The Committee notes from the patient's records that there is a record of a CBCT on 13 June 2017. There is however no report on the same. The Committee accepts Professor Brook's evidence that Mr Hashmi was under a duty to make both a record and report, and it finds that he did not make any report, but did make a record of it. Mr Holden's evidence is similarly that there is no report or grading of the radiograph. The Committee notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee therefore finds the facts at this head of charge proved to the extent of there being no report.
44. i)	*treatment provided on 25 August 2017 including the placement of implants and the subsequent fitting of a lower overdenture.* **Proved**
	The Committee finds the facts alleged at head of charge 44 (i) proved. The Committee notes from Patient's 22's records that there is some limited information relating to the placement of implants on 25 August 2017 and a reference to an overdenture. The Committee notes that Professor Brook is critical of shortcomings in this record. It also notes that Mr Holden stated that, if the Committee were to conclude that Mr Hashmi's entry represents his complete record, he would be critical of Mr Hashmi's record-keeping in this regard. The Committee accepts the expert evidence of Professor Brook that Mr Hashmi was under a duty to make a record of treatment. As he did not do so adequately, Mr Hashmi failed in this duty. The Committee also notes from his witness statement that Mr Hashmi accepts this head of charge.
45.	*When discussing treatment options, you inappropriately:*
45. a)	*offered a partial chrome denture on 21 December 2016 which was not suitable given the status of the remaining teeth;* **Proved**

	The Committee finds the facts alleged at head of charge 45 (a) proved. The Committee also notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes that in Mr Hashmi's records for the patient he recorded that on 21 December 2016 he suggested the option of a partial chrome denture, but that the patient did not want such a denture. Professor Brook's evidence is that such an option, although rejected by the patient, was 'totally inappropriate' and was not indicated. Mr Holden concurs that such a partial chrome denture was 'contraindicated'. The Committee accepts the expert evidence that such a denture was inappropriate, and it therefore finds the facts alleged at this head of charge proved.
45. b)	*offered root canal therapy and crowns on 15 February 2017 which were not suitable given the status of the remaining teeth.* **Proved**
	The Committee finds the facts alleged at head of charge 45 (b) proved. The Committee also notes that Mr Hashmi accepted this head of charge in his witness statement. The Committee notes that in Mr Hashmi's records for the patient he recorded that on 15 February 2017 he suggested the option of root canal therapy (RCT) and crowns. Professor Brook's evidence is that such treatment was not appropriate. Mr Holden concurs with Professor Brook's assessment. The Committee accepts the expert evidence that such an offer of treatment was inappropriate, and it therefore finds the facts alleged at this head of charge proved.
Patient payments	
46.	*Between about 29 July 2017 and 18 March 2018 whilst working at the Practice you obtained payments directly from patients:*
46. a)	*in cash which you retained;* **Proved**
46. b)	*by transfer direct to your own personal bank account.* **Proved**
	The Committee finds the facts alleged at heads of charge 46 (a) and 46 (b) proved. Witness A's evidence is that, whilst reviewing the care and treatment that Mr Hashmi provided to the patients referred to above, it appeared that a number of patients had been invited to correspond with Mr Hashmi via his personal email address and were asked to make payment to him, either in

	the form of cash or by direct bank transfer to his own bank account. The evidence presented to the Committee demonstrates that Mr Hashmi obtained monies, either in cash or by transfer direct to his own personal bank account, from approximately 13 patients. Witness A estimates that the total sum of monies obtained by such means was between £60,000 and £80,000. In police interview under caution arising from Witness A's concerns Mr Hashmi admitted to taking payments from around six or seven patients over a period of six or seven months. The Committee finds from the evidence presented to it that Mr Hashmi obtained payments directly from patients both in the form of cash which he retained and by direct transfer to his own personal bank account. The Committee considers that the evidence presented to it, including the acceptances set out by Mr Hashmi in his witness statement, demonstrates that such monies were obtained. In relation to receiving cash, the Committee finds that the evidence demonstrates that such monies were received by those means from Patient 1, Patient 2, Patient 5, Patient 8, Patient 13, Patient 14, Patient 18, Patient 23 and Patient 25. In relation to receiving payments by direct transfer to Mr Hashmi's own personal bank account, the Committee finds that the evidence demonstrates that monies were received by those means from Patient 6, Patient 9, Patient 15 and Patient 22.
47.	*You concealed from the Practice the payments you obtained from patients.* **Proved**
	The Committee finds the facts alleged at head of charge 47 proved. In police interview Mr Hashmi stated that he received payments directly from patients. He stated that he had not recorded the amounts of money paid directly to him on the corresponding records for each patient, meaning that sums would be showing as outstanding on file despite the patients in question having paid the amounts that were owing directly to Mr Hashmi. As set out above the Committee finds that Mr Hashmi used his own personal email account for the purposes of obtaining monies from patients rather than his practice work email address. The evidence presented to the Committee is that Mr Hashmi obtained money from patients, whether in cash or by direct transfer to his personal bank account, without the knowledge of the practice. Witness A's evidence is that Mr Hashmi's actions were done without the practice being aware of what was happening. The evidence presented to the Committee suggests that Mr Hashmi was acting outside of, and without reference to, the usual procedures for financial transactions for dental care and treatment, with no central or practice-held records of the sums that were being paid directly to him. In this way, sums of money paid directly to Mr Hashmi would show as not having been paid on the practice records. Mr Hashmi also accepts that he did not inform the practice of the payments that he was receiving directly. The Committee

	therefore finds that Mr Hashmi concealed the payments from the practice. The Committee therefore finds the facts alleged at head of charge 47 proved.
48.	*You concealed from patients that their payments ought not to have been paid to you.* **Proved**
	The Committee finds the facts alleged at head of charge 48 proved. The evidence presented to the Committee is that Mr Hashmi conveyed the impression to patients that it was acceptable and usual for them to pay him directly rather than through the normal practice channels. Mr Hashmi does not appear to have explained that the sums paid were to be retained by him and were not going to the practice. The Committee considers that Mr Hashmi was, therefore, concealing from patients that the monies that he was obtaining from them should instead have been paid directly to the practice.
49.	*Your conduct as set out above at 46(a) and/or 46(b) and/or 47 and/or 48 was:*
49. a)	*misleading;* **Proved**
	The Committee finds the facts alleged at head of charge 49 (a) proved. The Committee considers that the evidence presented to it demonstrates that patients from whom Mr Hashmi received monies were misled into believing that the payments that they made to him directly were being made properly, with the beneficiary being the practice rather than Mr Hashmi. Instead, Mr Hashmi, rather than the practice, was the beneficiary. The evidence also demonstrates that these direct payments were made without the knowledge of the practice for whom Mr Hashmi worked. The practice did not know of the fact of these direct payments until some time later when Witness A came to review patient records for different purposes, and by Mr Hashmi's own acceptance there was no central, practice-held record of these direct payments. Therefore, both patients and the practice were misled, and the Committee finds the facts alleged at this head of charge proved.
49. b)	*dishonest in that you knew you were not entitled to:*
49. b) i)	*take patient payments directly; and/or* **Proved**
49. b) ii)	*retain patient payments.* **Proved**
	The Committee finds the facts alleged at heads of charge 49 (b) (i) and 49 (b) (ii) proved. In approaching heads of charge 49 (b) (i) and (ii), the Committee applied the test set out in Ivey v Genting Casinos (UK) Ltd. t/a Crockfords [2017] UKSC

	67. The test is that the Committee must decide subjectively the actual state of Mr Hashmi's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether his conduct was dishonest by those standards. As stated above, in police interview under caution arising from Witness A's concerns Mr Hashmi admitted to taking payments from around six or seven patients over a period of six or seven months. He described that his purpose was 'kind of future planning' on account of him leaving the practice and believing that he would not be paid the salary owing to him. He stated that he believed that he would be owed a certain amount of money at the end of his contract, and that his 'ring fencing' of patient monies would mean that he had 'got that there' so that he would be in a position to 'argue with [Witness A] to try and come out with a reasonable fair amount to us both'. Mr Hashmi stated that his methods were not conventional, but he maintained that he had acted properly and had not deceived patients. Mr Hashmi stated that he had prepared a schedule of payments prior to attending the police interview. In his later witness statement to the GDC for the purposes of these proceedings, Mr Hashmi accepted that, 'with the benefit of hindsight, I accept my actions were not justified'. The Committee has found at the preceding heads of charge that Mr Hashmi obtained payments directly from patients, that he concealed those payments from his practice, that he concealed from the patients concerned that their payments should not have been made in such a manner, and that his conduct was misleading in those respects. The Committee first of all considered the actual state of Mr Hashmi's knowledge or belief as to the facts. As set out above, Mr Hashmi's account is that he considered that Witness A would withhold his salary following him tendering his resignation. The Committee does not accept his account. The Committee notes that Mr Hashmi tendered his resignation in February 2018, which postdates the start of him receiving direct payments from patients by a number of months. Mr Hashmi was being paid regularly. This is highly suggestive of Mr Hashmi not being of a genuine belief that he would not be properly paid at the time at which he received direct patient payments. The Committee also notes that Mr Hashmi only prepared his own schedule of payments prior to attending the police interview. This demonstrates that Mr Hashmi was not making records of payments at the times at which he was requesting them, and that there was no pre-planned 'ringfencing'. This is also highly suggestive of a state of mind characterised by an intention to mislead patients and obtaining monies dishonestly. The Committee therefore considers that Mr Hashmi's attempts to explain his conduct in terms of strengthening his bargaining position with Witness A and the practice are not credible. The Committee finds that his actions were motivated by financial gain for himself. The Committee noted that the majority of the direct payments were obtained over a period of time when Witness A was away from the practice on maternity leave, meaning that Mr Hashmi was likely to be under less scrutiny.

	The Committee is of the view that, even if it were to have accepted Mr Hashmi's explanation, in other words to have accepted that his belief was genuine, it would have found his conduct dishonest. Having determined Mr Hashmi's actual state of knowledge and belief, the Committee went on to apply the objective standards of ordinary and decent people to determine whether his conduct was dishonest by those standards. The Committee considers that Mr Hashmi's conduct was dishonest by reference to those standards. The Committee considers that Mr Hashmi consistently concealed his actions at a time when Witness A was absent, both from the practice and from the patients themselves. The Committee considers that this surreptitious conduct was motivated by financial gain, and would be viewed as dishonest by an ordinary and decent person. For these reasons, the Committee finds the facts alleged at heads of charge 49 (b) (i) and 49 (b) (ii) proved.
Advertising	
50.	*On 22 January 2018 you were advised by the Case Examiners for the GDC to ensure, words to the effect, that any advertising:*
50. a)	*was accurate and did not have the potential to mislead;* **Proved**
50. b)	*did not permit for any ambiguity about your healthcare training.* **Proved**
	The Committee finds the facts alleged at heads of charge 50 (a) and 50 (b) proved. The Committee notes that on 22 January 2018 the GDC's CEs advised Mr Hashmi to ensure that his advertising was accurate with no potential to mislead, and did not permit any ambiguity about his training.
51.	*From July 2018 or earlier, you advertised yourself to prospective patients as being an 'Experienced Cosmetic Dentist' having undertaken, amongst other things, a 'Diploma in Facial Aesthetics'.* **Proved**
	The Committee finds the facts alleged at head of charge 51 proved. The evidence presented to the Committee demonstrates that Mr Hashmi advertised himself as an 'Experienced Cosmetic Dentist' on his own website, and that he had obtained a 'Diploma in Facial Aesthetics'. The Committee finds that this amounts to advertising. The Committee also notes that Mr Hashmi accepted the allegation in his witness statement.
52.	*The 'Diploma in Facial Aesthetics' is not a dental qualification.* **Proved**
	The Committee finds the facts alleged at head of charge 52 proved. The Committee notes that Mr Hashmi attended a four-day course relating to botox and dermal fillers in October 2017. The convenor of the course stated that the diploma course related to cosmetic procedures carried out on the

	face rather than procedures carried out on the teeth or the practice of dentistry. The Committee concludes that the qualification was therefore not a dental qualification. The Committee also notes that Mr Hashmi accepted the allegation in his witness statement.
53.	*Your conduct in respect of your advertising was:*
53. a)	*misleading;* **Not proved**
	The Committee finds the facts alleged at head of charge 53 (a) not proved. The Committee has found that Mr Hashmi has advertised himself as an 'Experienced Cosmetic Dentist' and has advertised himself as holding a Diploma in Facial Aesthetics in connection with being a dentist. The Committee does not find that the statement that Mr Hashmi made of him being an 'Experienced Cosmetic Dentist' is misleading. The Committee has not been provided with evidence to demonstrate that such a statement is incorrect and without a proper basis. The Committee notes that Mr Hashmi had experience of providing cosmetic dentistry and the language used in the advertisement did not qualify his level of experience. The Committee has also considered whether Mr Hashmi's reference to him holding a 'diploma in Facial Aesthetics' was a misleading statement. The Committee takes this diploma to be the same as that referred to at head of charge 52 above, namely a diploma in botox and dermal fillers. The Committee considers that it was not misleading for Mr Hashmi to describe the course as being one in facial aesthetics. The Committee also considered whether Mr Hashmi's reference to such a qualification in the context of his website was misleading. The reference to the diploma appeared beneath the heading of 'Experienced Cosmetic Dentist', and within a paragraph in which he referred to being a dentist. The Committee does not consider that an individual reading Mr Hashmi's advertising would be misled. Therefore, although the Committee notes that Mr Hashmi accepted that his advertising may have been misleading, in exercising its own independent judgement the Committee is not satisfied that Mr Hashmi's advertised statements were misleading.
53. b)	*dishonest in that you knew it was liable to mislead as to your dental qualifications.* **Not proved**
	As the Committee has found the facts alleged at head of charge 53 (a) not proved, it follows that head of charge 53 (b) falls away.
Indemnity	
54.	*Between 10 February 2013 and about 21 January 2019 you failed to ensure you had adequate indemnity insurance in that:*

54. a)	*in February 2013 you took out insurance on the basis you had commenced Foundation Training when you had not;* **Proved**
	The Committee finds the facts alleged at head of charge 54 (a) proved. The Committee noted that Foundation Training (FT) is a specific year of postgraduate training within an NHS setting. Mr Hashmi missed the opportunity to take up his FT post, having to resit his final undergraduate examinations. The Committee noted that a dentist taking up FT is also described as a 'Vocational Trainee' (VT). The Committee finds from the evidence presented to it that on 11 February 2013 Mr Hashmi had a telephone conversation with an indemnity insurance provider, namely Dental Protection, with a view to obtaining indemnity insurance. The evidence presented to the Committee is that during that conversation Mr Hashmi stated that he had commenced FT. However, when asked about this matter at a meeting with Dental Protection at their offices on 14 January 2019 Mr Hashmi accepted that at the time he was in fact a salaried associate in private practice at the relevant time. The evidence of Witness A is that Mr Hashmi was paid the salary equivalent to a VT, but that he was exclusively a private dentist working in a private practice. The Committee finds that Mr Hashmi was under a duty to hold adequate indemnity insurance as a requirement of registration. The Committee finds that Mr Hashmi did not take out the correct level of indemnity insurance, because it was assessed on the understanding that he had commenced FT when that was not in fact the case. Consequently, Mr Hashmi did not have adequate indemnity insurance between the dates specified above. The Committee therefore finds that Mr Hashmi failed in his duty to hold adequate indemnity insurance between the specified dates. Accordingly it finds this head of charge proved.
54. b)	*you thereafter renewed your insurance annually on the basis that you had commenced and/or completed Foundation Training when you had not;* **Proved**
	The Committee finds the facts alleged at head of charge 54 (b) proved. The Committee finds from the evidence presented to it that, having obtained indemnity insurance, Mr Hashmi continued to hold such indemnity insurance on an annual renewal basis. The renewal certificates that were issued referenced Foundation Training which Mr Hashmi had not in fact undertaken. The Committee has had sight of the annual certificates of dental membership issued by Dental Protection which give a grade description of 'VT […] completed', followed by the number of years of postgraduate practice. The Committee infers from these annual certificates that Mr Hashmi did not give an accurate declaration of his FT status when renewing his indemnity insurance each year. In their letter to Mr Hashmi dated 21 January 2019 Dental Protection stated that, 'the subscriptions that apply to these grades are less than what would apply to a person who had

	not completed Foundation Training'. The renewal declarations that Mr Hashmi was asked to complete have not been provided in their original completed form by Dental Protection, but the Committee is nonetheless satisfied from the evidence presented by Dental Protection that Mr Hashmi renewed his indemnity insurance on an incorrect basis, namely that he had commenced or completed Foundation Training when that was not the case. Mr Hashmi was asked to confirm the accuracy of the information when renewing each year, and the evidence presented to the Committee is that the incorrect information that Mr Hashmi had commenced or completed Foundation Training was not corrected by Mr Hashmi either as part of his annual renewal declaration or otherwise. The Committee is therefore satisfied that Mr Hashmi renewed his insurance annually on the basis that he had commenced or completed Foundation Training when that was not the case. Accordingly it finds the facts alleged at head of charge 54 (b) proved.
54. c)	*from about 2016 your practice included the provision of implants which was not covered by your insurance.* **Proved**
	The Committee finds the facts alleged at head of charge 54 (c) proved. The Committee has found above at earlier heads of charge that Mr Hashmi provided dental implants to a number of patients from around 2016. The renewal declaration that was sent to Mr Hashmi annually states that he was under a duty to inform Dental Protection of any change in his scope of practice. Mr Hashmi was also specifically asked whether he was carrying out the placing of implants. The certificates of renewal that Mr Hashmi received set out codes of membership which excluded the provision of implants. The evidence presented by Dental Protection, and more particularly in their letter to Mr Hashmi dated 21 January 2019, is that he was not, and had never been, in the membership grade applicable for such treatment. Mr Hashmi is reported as having said to Dental Protection in 2015 that he had completed an implant course, but that on 18 April 2017 he stated to them that he was considering attending such a course. Mr Hashmi was advised that he needed to be in the correct membership grade. Mr Hashmi then asked for a quote for an additional subscription which he did not then follow up. The Committee finds that Mr Hashmi provided implants from 2016 despite not being covered to do so by his indemnity insurance. Accordingly it finds the facts alleged at head of charge 54 (c) proved.
55.	*Your conduct in relation to charge 54 above was:*
55. a)	*misleading,* **Proved**

	The Committee finds the facts alleged at head of charge 55 (a) proved. The Committee has found above that Mr Hashmi took out, and subsequently renewed for approximately six years, indemnity insurance on the basis that Mr Hashmi had commenced Foundation Training when he had not in fact done so. The Committee has also found that, from around 2016, Mr Hashmi's practice included the provision of implants, which was not covered by his indemnity insurance. The Committee considers that Mr Hashmi's conduct in these respects was misleading, in that his indemnity insurance provider, namely Dental Protection, was misled into believing that he had commenced Foundation Training and that he was not providing implant treatment. The Committee therefore finds the facts alleged at head of charge 55 (a) proved.
55. b)	*dishonest.* **Proved**
	The Committee finds the facts alleged at head of charge 55 (b) proved. In approaching head of charge 55 (b) the Committee again applied the test set out in Ivey v Genting Casinos (UK) Ltd. t/a Crockfords [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of Mr Hashmi's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether his conduct was dishonest by those standards. The Committee first of all considered Mr Hashmi's actual state of knowledge and belief as to the facts. In his witness statement Mr Hashmi stated that he had a meeting with Dental Protection some time after March 2018, and that Dental Protection were not able to provide indemnity insurance to him on account of him having not commenced Foundation Training. He also stated that following the start of him providing implant treatment he was informed that his indemnity insurance was void. Mr Hashmi stated that he felt 'cheated and incredibly naïve' that he had trusted Witness A, and that he was 'shocked and devastated' The Committee does not accept Mr Hashmi's account. The Committee instead considers that Mr Hashmi knew that he did not hold adequate indemnity insurance both in relation to not having commenced Foundation Training and in relation to providing implant treatment. In relation to implants, Mr Hashmi's actual state of mind is revealed by his telephone conversation with Dental Protection of 18 April 2017 as referred to above in which he stated that he was considering an implant course. He was quoted a price for increased membership, but this was not pursued. This demonstrates that Mr Hashmi was clearly aware that his existing indemnity insurance was not adequate to cover implants, and that he did not take the necessary action to bring his indemnity insurance into line with his practice. The Committee also considers that the information about renewal provided by Dental Protection was clear, and that in any event it was not the responsibility of another registrant, and in this case Witness A, to explain

	that information to him. In terms of not having undertaken Foundation Training, on 11 February 2013 Mr Hashmi had a telephone conversation with Dental Protection, during which Mr Hashmi stated that he had commenced Foundation Training when he had not in fact done so. In his witness statement Mr Hashmi stated that 'all of his friends had gone into traditional NHS vocational training placements', which reveals that he was aware of the fact and nature of Foundation and Vocational Training. The Committee does not accept that Mr Hashmi did not know that he had not in fact commenced Foundation Training. Such a programme is a formal programme which is properly understood and commonly recognised within the profession, and its pertinence would have been especially clear to a recently-qualified dentist. The Committee therefore finds Mr Hashmi's proffered account of him having trusted Witness A, and having considered his training as being the same as Foundation Training, as implausible. The annual declarations that he received provided further clear and unequivocal reminders of Dental Protection's understanding of him having undertaken Foundation Training. As found above, Mr Hashmi did not at any point take the opportunity to correct the inaccurate declarations. The Committee then went on to apply the objective standards of ordinary and decent people to determine whether Mr Hashmi's conduct was dishonest by those standards. The Committee considers that Mr Hashmi's conduct would be viewed as being dishonest by reference to those standards. The Committee considers that Mr Hashmi's conduct was financially motivated, in that he sought to avoid paying the greater costs associated with the standard of indemnity insurance that the true nature of his practice would require. The Committee therefore finds that Mr Hashmi's conduct in respect of head of charge 54 was dishonest. Accordingly, it finds the facts alleged at head of charge 55 (b) proved.

We move to stage two."

On 12 May 2022, the Chairman announced the determination as follows:

Proceedings at stage two

"The Committee has considered all the evidence presented to it, both written and oral. It has taken into account the submissions made by Ms Barnfather on behalf of the General Dental Council (GDC). As set out previously Mr Hashmi was not in attendance at the hearing, save for the first two days, and was not represented in his absence. The Committee has not received any submissions, representations, further information or evidence from him following its factual findings. The Committee has however had regard to the information previously provided by Mr Hashmi insofar as it pertains to stage two, including his witness statement dated 21 July 2021.

In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has accepted the advice of the Legal Adviser.

Fitness to practise history

Ms Barnfather addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Barnfather stated that, as set out in the Committee's findings of fact, Mr Hashmi was issued with advice by the GDC's Case Examiners on 22 January 2018 regarding advertising practices. Ms Barnfather stated that Mr Hashmi has no other fitness to practise history.

Misconduct

The Committee first considered whether the facts that it has found proved constitute misconduct. Ms Barnfather submits that those facts amount to misconduct. In considering this matter, the Committee has exercised its own independent judgement.

In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the majority of the facts that it has found proved. These paragraphs state that as a dentist:

1.3 [You must] be honest and act with integrity.

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

1.8 You must have appropriate arrangements in place for patients to seek compensation if they have suffered harm.

3 [You must] obtain valid consent.

4.1 [You must] make and keep contemporaneous, complete and accurate patient records.

5.3 You must give patients who complain a prompt and constructive response.

7.2 You must work within your knowledge, skills, professional competence and abilities.

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.

The Committee's findings relate to a number of identified failings in Mr Hashmi's care and treatment of 14 patients, primarily over the period of 2017 to March 2018, as well as probity findings concerning patient payments and indemnity insurance arrangements.

The Committee has found that Mr Hashmi failed to maintain adequate patient records in key respects; that he failed to carry out adequate assessments and examinations, with particular regard to orthodontic and implant assessments; that he failed to obtain informed consent; that he provided orthodontic treatment when such treatment was not appropriate, and in some cases that such treatment was commenced before the patient's periodontal health had been secured; that his provision of implant treatment was poor; that in some cases he acted outside the limits of his competence in relation to implant and orthodontic treatment; and that he failed to respond to the solicitors acting for a patient in connection with a potential claim for the orthodontic treatment that he had provided.

The Committee has also found that Mr Hashmi obtained payments directly from patients, in cash or by direct transfer to his personal bank account, and hid his actions from the practice at which he worked. The Committee has found that Mr Hashmi concealed from the patients concerned that they should not have made payments directly to him. The Committee went on to find that Mr Hashmi's conduct was misleading and dishonest.

The Committee has also determined that Mr Hashmi failed to ensure that he had adequate indemnity insurance in place for a period of nearly six years. The indemnity insurance that Mr Hashmi obtained was subsequently withdrawn by his indemnifiers, and the withdrawal retrospectively applied and voided, in light of his indemnifiers' discovery that Mr Hashmi had not in fact commenced Foundation Training (FT). The Committee found that Mr Hashmi took out, and subsequently renewed, his indemnity insurance on a false basis, namely that he had commenced FT when that was not in fact the case. The Committee also found that Mr Hashmi renewed his indemnity insurance on another false premise, namely that he was not providing implant treatment when he was in fact providing such treatment. The Committee found that, in doing so, Mr Hashmi acted in a misleading and dishonest manner.

The Committee finds all of the facts that it has found proved as summarised above amount to misconduct for the following reasons.

The facts pertaining to clinical matters relate to acts and omissions which are wide-ranging, numerous, basic and fundamental. In three patient cases Mr Hashmi's care and treatment of the patients concerned constituted him acting outside the limits of his competence. Mr Hashmi's care and treatment of some of the patients in this case have caused actual harm. The Committee considers that, when taken together, Mr Hashmi's clinical failings constitute misconduct.

The Committee has also made findings of dishonest conduct in respect of patient payments and indemnity insurance arrangements.

The trust of patients, as well as of colleagues at his place of work, was betrayed by Mr Hashmi as a result of his deceitful and surreptitious obtaining of monies from patients. These amounts have been estimated by Witness A to be in the total sum of between £60,000 and £80,000. The Committee specifically identified 13 patients as having given monies directly to Mr Hashmi. The Committee considers that Mr Hashmi was motivated by personal financial gain, and that his conduct represents a considered, deliberate and sophisticated deception. The Committee considers that fellow practitioners would consider Mr Hashmi's actions to be nothing short of deplorable.

Mr Hashmi's failure to ensure that he had adequate indemnity insurance arrangements in place for a protracted period of several years was a further betrayal of trust, and has meant that patients who may have had cause to seek financial recompense were, and are, unable to do so through Mr Hashmi. The Committee is mindful that having adequate indemnity insurance arrangements in place is a fundamental requirement of registration. Mr Hashmi had a number of opportunities over a considerable period of time to correct the false basis upon which his indemnity insurance had been taken out and renewed. The evidence presented to the Committee is that one patient in particular, namely Patient 3, has not been able to obtain financial recompense from Mr Hashmi to resolve the issues that arose from Mr Hashmi's proven poor care and treatment of her.

The Committee therefore finds that all of the facts that it has found proved amount to misconduct.

The Committee has also made factual findings about advertisement statements that Mr Hashmi made about his practice, but it attaches no culpability to its findings. The Committee therefore does not consider that the facts that it has found proved in relation to Mr Hashmi's advertising practices at heads of charge 50, 51 and 52 amount to misconduct.

Deficient professional performance

Having determined that the facts that it has found proved amount to misconduct, the question of deficient professional performance falls away, given that the same facts cannot amount to both misconduct and deficient professional performance.

Impairment

The Committee then went on to consider whether Mr Hashmi's fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee has again exercised its independent judgement. The Committee heard from Ms Barnfather that the GDC submits that Mr Hashmi's fitness to practise is impaired. Throughout its deliberations, the Committee has borne in mind that its primary duty is to address the public interest, which includes the protection of patients, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

The Committee has concluded that Mr Hashmi's fitness to practise is currently impaired by reason of the misconduct that it has found for the following reasons.

The Committee considers that, whilst Mr Hashmi's clinical acts and omissions might be capable of being remedied, relating as they do to identifiable, basic and fundamental aspects of practice, Mr Hashmi has not shown any meaningful insight into his misconduct beyond making a number of admissions to record-keeping allegations that the Committee went on to find proved. The Committee has not been provided with any information to suggest that Mr Hashmi has taken steps to remedy the clinical failings that the Committee has identified, or indeed that he has any inclination of doing so in the future. The clinical shortcomings are serious, wide-ranging and fundamental, and suggest that patients would be put at risk of harm were there to be a repeat of such acts and omissions. Such a repeat cannot in the Committee's judgment be said to be highly unlikely on account of the lack of insight and remediation put forward by Mr Hashmi.

The Committee is mindful that the dishonesty that it has found, both in respect of Mr Hashmi's obtaining of payments directly from patients and his inadequate indemnity insurance arrangements, might be more difficult for him to remedy, as it is suggestive of a professional attitudinal problem. In any event, the Committee has not been provided with evidence of any meaningful insight into, or remediation of, the dishonest conduct that it has found. In his witness statement prepared for these proceedings, Mr Hashmi stated that, in relation to his obtaining of monies directly from patients, *'with the benefit of hindsight, I accept my actions were not justified'*. However, the Committee has not been provided with any information from Mr Hashmi to suggest that he recognises the gravamen of his dishonest conduct, including its serious consequences for patients as well as for the trust between practitioners and patients and the standing and reputation of the profession. Rather than expressing remorse for his harmful actions, Mr Hashmi appears to continue to apportion blame to Witness A for his conduct and sought to present his actions in the context of his apparent difficulties with her. The Committee has similarly not been provided with any

information from him that he recognises the seriousness and consequences of his failure to ensure that he held adequate indemnity insurance.

In the Committee's judgment these two facets of dishonest conduct are deeply damaging to Mr Hashmi's fitness to practise. Although these facets arose in different aspects of practice and manifested themselves in different ways, the Committee considers that they are highly suggestive of Mr Hashmi's harmful subordination of patient interests to his own. In the Committee's judgment Mr Hashmi was motivated by financial gain, both in the form of obtaining payments directly from patients by surreptitious means and by avoiding the higher payment rates of indemnity insurance that the true nature of his practice required. Mr Hashmi's lack of insight into, and remediation of, such serious dishonesty means that Mr Hashmi continues to pose an unwarranted risk of harm to the safety and wellbeing of the public.

The Committee is also in no doubt that the especially serious nature of its factual findings, particularly those relating to dishonesty, require a finding of impairment in the public interest. Mr Hashmi's dishonest conduct has breached a fundamental tenet of the profession, namely the need to act with honesty and integrity, and has brought the reputation of the profession into disrepute. Such dishonesty was directly related to Mr Hashmi's practice as a dentist and amounts to a breach of trust, including the trust placed in him by patients, his colleagues at his practice and his professional indemnifiers. The Committee considers that the public's trust and confidence in the profession, and in the regulatory process, would be seriously undermined if a finding of impairment were not made in the particular circumstances of this case. A finding of impairment is especially mandated in order to maintain the public's trust and confidence in the profession, and to declare and uphold proper standards of conduct and behaviour, given that these fundamentally important public interest considerations have been so undermined by Mr Hashmi's conduct.

Sanction

The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests referred to above. The Committee has heard that Ms Barnfather on behalf of the GDC invites the Committee to erase Mr Hashmi's name from the register.

In reaching its decision the Committee has again taken into account the GDC's Guidance for the Practice Committees, including Indicative Sanctions Guidance (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with Mr Hashmi's own interests.

The Committee has considered the aggravating and mitigating factors present in this case.

In terms of mitigating factors, Mr Hashmi made a number of admissions to the record-keeping allegations that the Committee went on to find proved. The Committee also notes that Mr Hashmi is of previous good character.

In relation to aggravating factors, Mr Hashmi caused harm, including financial harm, to patients, for instance Patient 3, and placed other patients at risk of harm, including by frustrating any claims for financial recompense by not having adequate indemnity insurance in place. Mr Hashmi's obtaining of patient payments directly also created the potential for financial loss to the practice at which he was employed. Mr Hashmi's conduct included

serious dishonesty of a premeditated, sustained, repeated and multifaceted kind. Mr Hashmi's dishonest conduct amounted to a breach of trust between him, his employers and colleagues, and his indemnity insurance providers. Mr Hashmi's dishonest conduct in not having adequate indemnity insurance in place also constitutes a blatant and wilful disregard for the systems regulating the profession, given that holding adequate indemnity insurance is a requirement of registration. Mr Hashmi has also, as set out above, demonstrated that he lacks meaningful insight into his misconduct.

The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of the findings made, the Committee has determined that it would be wholly inappropriate and disproportionate to conclude this case with no action or with a reprimand. The Committee's findings of repeated, serious and multifaceted dishonest conduct mean that taking no action, or issuing a reprimand, would be entirely insufficient to protect the public, maintain public confidence and trust in the profession and in the regulatory process, and would not declare and uphold proper standards of conduct and behaviour.

The Committee next considered whether a period of conditional registration would be appropriate. In the Committee's judgment a period of conditional registration would similarly not be sufficient, appropriate or proportionate in light of the public protection and public interest considerations that the Committee has identified. Conditions would not be workable, as Mr Hashmi is not engaging in these proceedings and the Committee would therefore not be able to be satisfied that he would comply with conditions even if such an outcome was proportionate. The Committee has also made multiple findings of dishonest conduct, and such misconduct does not lend itself to being addressed by way of conditions. In any event, the Committee considers that a period of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour or maintain trust and confidence in the profession.

The Committee therefore went on to consider whether to suspend Mr Hashmi's registration. The Committee concluded that a period of suspension would not be sufficient to meet the public protection and public interest considerations of this case. Mr Hashmi's conduct, and in particular his dishonest conduct, is of a particularly serious kind, relating as it does to a fundamental breach of trust between him and patients, as well as between him and his colleagues, employer and indemnifier. Mr Hashmi caused significant harm to patients, with particular regard to his lack of adequate indemnity insurance, as this had the consequence of denying patients access to financial recompense from Mr Hashmi to which they might have been entitled. This risk of serious harm remains on account of Mr Hashmi's lack of insight and remediation. Put simply, Mr Hashmi put his own interests, and particularly his own financial interests, before the interests of his patients on repeated occasions over a considerable period of time and in different ways. Mr Hashmi has not provided information to suggest that he recognises the damage that his misconduct has caused to the public or to the wider public interest. This represents conduct which is fundamentally incompatible with registration, and the breach of trust is so serious that no lesser sanction than that of erasure is appropriate. The Committee recognises that erasure from the register may cause hardship to Mr Hashmi, but considers that his interests are outweighed by the need to protect the public and the public interest. Therefore, the ultimate sanction of erasure is required to protect the public, to declare and uphold proper standards of conduct and behaviour, and maintain public trust and confidence in the profession and in the regulatory process.

The Committee therefore directs that Mr Hashmi's name be erased from the register.

Existing interim order

In accordance with Rule 21 (3) of the General Dental Council (Fitness to Practise) Rules 2006 and section 27B (9) of the Dentists Act 1984 (as amended) the interim order of conditions in place on Mr Hashmi's registration is hereby revoked.

Immediate order

Having directed that Mr Hashmi's name be erased from the register, the Committee then invited submissions as to whether it should impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended).

Having directed that Mr Hashmi's name be erased from the register, the Committee invited submissions as to whether it should impose an order for his immediate suspension in accordance with section 30 (1) of the Dentists Act 1984 (as amended). The Committee has once more had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

Ms Barnfather on behalf of the GDC submitted that an immediate order is necessary to protect the public and is also in the public interest.

The Committee has accepted the advice of the Legal Adviser.

In all the circumstances, the Committee considers that an immediate order of suspension is necessary to protect the public and is otherwise in the public interest. The Committee has determined that, given the risks that it has identified, it would not be appropriate to permit Mr Hashmi to practise before the substantive direction of erasure takes effect. The Committee considers that an immediate order for suspension is consistent with the findings that it has set out in its main determination.

The effect of the foregoing determination and this immediate order is that Mr Hashmi's registration will be suspended from the date on which notice of this decision is deemed served upon him. Unless he exercises his right of appeal, the substantive direction of erasure will be recorded in the dentists' register 28 days from the date of deemed service. Should Mr Hashmi so decide to exercise his right of appeal, this immediate order of suspension will remain in place until the resolution of any appeal.

That concludes this case."