

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

13-17 April 2026

Name: IWANICKI, Jaroslaw Michal

Registration number: 252779

Case number: CAS-210485-Q4B1N5

General Dental Council: Christopher Saad, Counsel
Instructed by IHLPS

Registrant: Not Present
Unrepresented

Fitness to practise: Impaired by reason of misconduct

Outcome: Erased

Immediate order: No Immediate order

Committee members: Jill Crawford (Chair and Lay Member)
Sobiah Satar (Dentist Member)
Emma Haywood (Dental Care Professional Member)

Legal adviser: Paul Moulder

Committee Secretary: Kate Anderson

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against Mr Iwanicki that his fitness to practise is impaired by reason of misconduct.
2. Mr Iwanicki was not present at the hearing and was unrepresented. Mr Christopher Saad, Counsel, appeared on behalf of the General Dental Council (GDC).
3. The hearing was held remotely on Microsoft Teams.

Preliminary Matters

Application to proceed with the hearing in the absence of the registrant

4. At the outset, Mr Saad made an application under Rule 54 of the GDC (Fitness to Practise) Rules Order of Council 2006 ('the Rules'), to proceed with the hearing notwithstanding Mr Iwanicki's absence.
5. Mr Saad drew the Committee's attention to the relevant documents on service and submitted that Mr Iwanicki had been notified of this hearing in accordance with the Rules. He outlined that a copy of the Notice of Hearing dated 13 March 2026 was sent to Mr Iwanicki at his registered address.
6. Mr Saad further referred to the unsuccessful attempts made by the GDC to contact Mr Iwanicki using his registered telephone numbers and two known email addresses. Mr Saad submitted that Mr Iwanicki has not kept his registered address, registered email address, or registered mobile number held by the GDC up to date, and this is a requirement of a registrant. He submitted that there had been efforts made by the GDC to contact Mr Iwanicki dating back to 27 May 2025, but that these had all been unsuccessful.
7. Mr Saad reminded the Committee that there is no requirement under the Rules for the Council to prove that the Notice of Hearing was received, only that it was sent, and he submitted that the GDC had met this requirement.
8. Mr Saad submitted that Mr Iwanicki had voluntarily absented himself. Mr Saad submitted that there had not been any request from him for an adjournment, and there was no indication that he would attend a hearing on a future date. He also referred the Committee to the background of this case and submitted that Mr Iwanicki is not a registrant who has engaged with these proceedings thus far.
9. The Committee took account of Mr Saad's submissions, and the supporting documentation he drew to its attention. The Committee accepted the advice of the Legal Adviser in relation to the issues of service and proceeding with a hearing in the absence of a registrant.

Decision on service

10. The Committee considered whether notice of the hearing had been served on Mr Iwanicki in accordance with Rules 28 and 65 of the Rules and section 50A of the Dentists Act 1984 (as amended) (hereby referred to as 'the Act').
11. The Committee had before it a copy of the Notice of Hearing, dated 13 March 2026 (hereafter 'the notice'), which was sent to Mr Iwanicki's registered address in Poland by international tracked and signed air mail. A copy was also sent to him by email to his two registered email addresses.

12. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the notice, only that it was sent. However, the Committee noted from Royal Mail's Track and Trace, that it was noted as delivered on 19 March 2026. The Committee was satisfied from the proof of postage information provided, that the GDC had met the requirement to send notice to Mr Iwanicki.
13. The Committee was further satisfied that the notice sent to Mr Iwanicki complied with the 28-day notice period required by the Rules, and that it contained all the required particulars, including the date and time of the hearing, and that it was intended that the hearing would take place remotely by Microsoft Teams video-link. Mr Iwanicki was also advised in the notice that the Committee had the power to proceed with the hearing in his absence.
14. On the basis of all the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Iwanicki in accordance with the Rules and the Act.

Decision on whether to proceed with the hearing in the absence of the registrant

15. The Committee next considered whether to exercise its discretion under Rule 54 to proceed with the hearing in the absence of Mr Iwanicki. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of R v Jones [2002] UKHL 5, and as affirmed in subsequent regulatory cases. It took into account that fairness to Mr Iwanicki was an important consideration but also bore in mind the need to be fair to the GDC and to act expeditiously in the public interest.
16. The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr Iwanicki of the hearing. In reaching its conclusion, it took into account that the last time Mr Iwanicki had been in contact with the GDC was in 2024 in which he stated he wanted to be removed from the register, and that since then it appeared that he had disengaged from the GDC process. The Committee noted that from this date, all emails sent to this email address have been returned as undeliverable, and the GDC has received no response to any communication. The Committee noted that there was no evidence before it of reasons for Mr Iwanicki's absence and disengagement. It inferred that Mr Iwanicki had voluntarily absented himself from this hearing by disengaging from the regulatory process.
17. It was the conclusion of the Committee that adjourning the hearing would serve no meaningful purpose in the circumstances. It noted that Mr Iwanicki had not requested an adjournment and there was no information before it to suggest that deferring the hearing would secure Mr Iwanicki's attendance in future.
18. The Committee remained mindful of the overarching statutory objective of the GDC, which is the protection of the public and the wider public interest, and its duty to act expeditiously in the public interest. The Committee also took into account the need to be fair to the GDC, noting that it is prepared and ready to present its case.
19. The Committee was satisfied, having balanced the public interest and fairness to the regulator with fairness to Mr Iwanicki, that the balance weighed in favour of proceeding with the hearing in Mr Iwanicki's absence.

Admitting Hearsay evidence

20. Mr Saad asked the Committee if it had any questions for the GDC witnesses, or whether it was content for their statements to be entered into evidence. The Committee therefore of its own

volition considered whether the evidence of the three GDC witnesses could be admitted as hearsay evidence under rule 57(1) of the Rules.

21. The Committee heard legal advice from the legal adviser, who made reference to the relevant rules.
22. The Committee noted that each of these witnesses were GDC officers, who gave evidence from their consideration of the GDC's records. The Committee had no questions which they wished to ask of the witnesses to clarify any information. The Committee also noted that Mr Iwanicki would have been sent the formal witness statements as part of the hearing bundle sent to him before the hearing took place. He was not present at the hearing and the Committee was not aware of any challenge to the content of the witness statements. Furthermore, the Committee was satisfied that the witnesses would have no reason to fabricate any of the content of their statements.
23. The Committee appreciated that should these witnesses not attend to give evidence in person, the evidence would be hearsay. However, having considered the information above, the Committee determined that it would be fair, appropriate, and a proportionate use of regulatory resource for the three GDC witness statements to be admitted as hearsay evidence. Notwithstanding the admission of the statements, the Committee would give the statements the appropriate weight in due course, as it would with its assessment of all of the evidence.

Charges

24. "That being a registered dentist:

Patient 1

Clinical care

1. You failed to provide an adequate standard of care to Patient 1 from 14 September 2016 to 6 May 2021, including by; -

- a) not carrying out sufficient diagnostic assessments.

Standard of record keeping

2. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 14 September 2016 to 06 May 2021 in respect of:-

- a) not recording a justification for taking the OPG (panoramic) radiographs on 12 October 2016 and/or 23 January 2019
- b) not grading for quality the OPG (panoramic) radiographs taken on 12 October 2016 and/or 23 January 2019,
- c) not reporting on the OPG (panoramic) radiographs taken on 12 October 2016 and/or 23 January 2019.
- d) The handwriting is difficult to interpret and contains words and abbreviations which are indecipherable

Not retaining records

3. You failed to retain adequately or at all, the dental records in respect to Patient 1's appointments from 14 September 2016 to 06 May 2021 including:-

- a) treatment between 06 December 2016 and 09 November 2017;
- b) photographs taken on 14 September 2016 and/or 13 February 2018 and/or 11 September 2018;
- c) the study models from 12 October 2016;

Patient 2

Clinical Care

4. You failed to provide an adequate standard of care to Patient 2 in that:

- a) the brackets on the lower incisors are poorly positioned;
- b) the outcome of the upper arch treatment was poor

Record keeping

5. You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments from 31 March 2016 to 18 January 2017 in respect of:

- a) The records are handwritten and difficult to decipher.

Not retaining records

6. You failed to retain adequately or at all, the dental records in respect to Patient 2's appointments in respect to:-

- a) Clinical photographs taken on 09 December 2015;
- b) Clinical photographs taken on 31 March 2016;
- c) Clinical photographs taken on 14 September 2016.
- d) All treatment undertaken in Poland during the course of orthodontic treatment
- e) The removal of the braces after 18 January 2017
- f) You deleted clinical photographs of Patient 2.

Not providing records

7. You failed to provide Patient 2 with a copy of their clinical records when requested.

8. You failed to provide the Practice with a copy of Patient 2's clinical records when requested.

GDC Cooperation

9. From 22 June 2021 to present, you failed to co-operate with the GDC in that you did not:

- a) Maintain up to date contact details;
- b) Respond to communications sent by the GDC.

And that by reasons of the matters alleged above, your fitness to practise is impaired by reason of misconduct'

Background to the case and summary of allegations

25. In opening the case for the GDC, Mr Saad provided the Committee with oral submissions of details of the charges and of the background of this case.
26. Mr Saad submitted that Mr Iwanicki is a registered dentist and was self-employed at the Practice on a contractual basis between 2014 and 2018 as an associate orthodontist. He submitted that following disagreements about the contract, Mr Iwanicki's engagement at the Practice came to an end. Mr Saad submitted that the Practice Manager (Witness A) had stated that there was a responsibility on clinicians to be responsible for their own notes and that when parties parted ways, the company would request the dental records. Mr Saad submitted that Mr Iwanicki did not adhere to this requirement. Mr Iwanicki also did not provide records when requested by patients. He also submitted that Mr Iwanicki had said that he had taken some models back to Poland with him, and that he had taken photos for his own purposes, for example, to remember where he was at in the treatment or because it was interesting. On 26 March 2018, Mr Iwanicki was asked to return all diagnostic models relating to his patients at the Practice, which he did not do. Mr Iwanicki sent an email on 3 April 2018 in which he stated that he would not return patient records to the Practice until an outstanding debt owed to him by the company had been paid to him.
27. Mr Saad submitted that following these events, the GDC received a complaint in relation to Mr Iwanicki. In its subsequent investigation, it instructed a dental expert who assessed the records that had been provided for Patient 1 and Patient 2. In his report, Dr Kidner (the expert), opined there were failings in regard to Mr Iwanicki's radiographic practice in recording justifications, grading and reporting. He was also of the opinion that there were issues with dental records such as poor handwriting and indecipherable abbreviations, a failure to maintain and retain adequate records, and issues surrounding the location of records and whether or not they were in Poland. Mr Saad submitted that the Dr Kidner had stated that these issues all fell below the standard expected.
28. Mr Saad also submitted that there was a failure to cooperate with the GDC's investigation by Mr Iwanicki. He submitted that there are three GDC staff witness statements provided to the Committee detailing these failings. Mr Saad submitted that it is the duty of a GDC registrant to keep details up to date and that Mr Iwanicki had appeared to do this until 2024 before, stopping all correspondence with the GDC.

Evidence

29. As part of the GDC's case, the Committee received evidence which included the following witness statements and/or associated exhibits from the following:
- Witness statement from Witness A
 - Witness statement from Sonia Sowan, GDC registrations team
 - Witness statement from Ashley Maswodza, GDC IHLPS Paralegal
 - Witness statement from Katherine McGirr, GDC Policy team

30. The Committee also heard oral evidence from Witness A.
31. The Committee received the dental records and translated email communications for Patients 1 and 2.
32. The Committee further received an expert report, dated 10 March 2026, from Mr Giles Kidner, who also gave oral evidence in which he largely confirmed the opinions set out in his report. He also answered questions put to him by the Committee.

Rule 18 Application to amend charge 2c

33. The Committee asked questions of clarification to the expert witness about charge 2c. The expert re-analysed the information presented, and opined that the records did in fact appear to show that the registrant reported on the OPG radiographs taken on 23 January 2019. In oral evidence he withdrew his criticism in his written report in relation to the non-reporting of OPG radiographs on 23 January 2019.
34. Mr Saad consequently made an application to amend charge 2c to remove '*and/or 23 January 2019*'. Mr Saad submitted that this charge was no longer supportable and therefore should be removed from the charges.
35. The Committee heard and accepted the advice of the Legal Adviser, who advised the Committee that it had the power to amend the charge, even at a late stage.
36. The Committee was satisfied that, having regard to the merits of the case and the fairness of the proceedings, removing the second date at charge 2c could be done without injustice. It noted that the expert had reviewed the evidence in the records and withdrawn his previous criticism. The Committee agreed that the records did not support a finding that Mr Iwanicki failed to report on the radiographs of 23 January 2019 and accepted that there was no longer a basis for the expert's previous criticism in relation to this date. The Committee therefore acceded to Mr Saad's application and allowed the amendment to charge 2c to remove this date.

The Committee's findings of fact

37. The Committee considered all the evidence presented to it, both documentary and oral. It also took account of the submissions made by Mr Saad on behalf of the GDC.
38. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation and how to approach the evidence.
39. In making its findings on the facts, the Committee bore in mind that the burden of proof rests with the GDC. There was no requirement for Mr Iwanicki to prove anything. It also reminded itself that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters are proved.
40. The Committee considered each head of charge separately and made the following findings:

"That being a registered dentist:

Patient 1	
1	<i>You failed to provide an adequate standard of care to Patient 1 from 14 September 2016 to 6 May 2021, including by; -</i>
1a	<p><i>not carrying out sufficient diagnostic assessments.</i></p> <p>Found Proved</p> <p>The Committee considered the evidence provided by Mr Kidner, the expert witness in this case. In his written report, he states that notes from the consultation Mr Iwanicki carried out on 14 September 2019 were '<i>brief handwritten notes</i>' and '<i>don't record any diagnostic details</i>'. The Committee also noted that Mr Kidner's conclusion was that '<i>The registrant fell far below the standard expected for diagnostic assessments before carrying out orthodontic treatment. The brief assessment that is recorded, is inadequate because important diagnostic details have not been included.</i>' In assessing the expert evidence, the Committee considered the Expert's credentials to be relevant and his written report to be balanced, reflecting an understanding of the impartiality of the expert role. In his oral evidence, the Committee found the expert to be willing to reflect on and reassess his position where appropriate. The Committee accepted the opinion of the expert that Mr Iwanicki failed to provide an adequate standard of care to Patient 1 in that he did not carry out sufficient diagnostic assessments. The Committee therefore determined that charge be found proved.</p>
2	<i>You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 14 September 2016 to 06 May 2021 in respect of:-</i>
2a	<p><i>not recording a justification for taking the OPG (panoramic) radiographs on 12 October 2016 and/or 23 January 2019</i></p> <p>Partly found Proved</p> <p>The Committee first considered the charge in relation to 12 October 2016. The Committee had regard to the opinion of Mr Kidner, who stated that there was no justification for taking the radiographs on 12 October 2016 recorded in the notes. Mr Kidner referred to IR(MER)17 guidelines which stipulates, as a regulatory requirement, the need to record justification of all dental radiographs.</p> <p>Mr Kidner's report stated that Mr Iwanicki '<i>fell far below the standard expected with his radiographic practice because he did not record a justification for taking the OPG (panoramic) radiographs</i>'. The Committee noted from the clinical records provided to it that there was a note that of '<i>new OPG</i>' on 12 October 2016 however it appeared to the Committee there is no recorded justification for these radiographs. It accepted the opinion of the expert witness that Mr Iwanicki ought to have recorded such justification for the radiographs of 12 October 2016 and he failed to maintain an adequate standard of record keeping for Patient 1 in respect of this omission. It therefore finds this charge proved in relation to 12 October 2016.</p> <p>The Committee next considered this charge in relation to 23 January 2019. The Committee carefully considered the clinical records provided to it. It considered that on 18 October 2018, it appears (despite the poorly handwritten notes) that there is a note by Mr Iwanicki stating '<i>painful around UR2</i>' in relation to Patient</p>



	<p>1. In Mr Kidner's answering of clarification questions by the committee, he accepted that if this is what the note says, it could be justification for the OPG to be taken.</p> <p>There was a further note, seemingly by a different hand, on 22 January 2019 stating that the patient is complaining her tooth hurts, had cancelled the OPG appointment on two occasions, and that the OPG was now scheduled for the following day. A subsequent note, apparently by the same hand, indicated that the patient reported that the pain had reduced on the morning of the scan but that she was advised an OPG was still needed.</p> <p>Mr Kidner further opined that the radiographs should have been rejustified if the pain had reduced, although there was no information before the Committee about any communication of this from the patient to Mr Iwanicki. Taking into account the records and the oral expert evidence, the Committee considered the note of 18 October 2018, on the balance of probabilities, shows justification of the radiographs taken on 23 January 2019. It accordingly found this charge in relation to 23 January 2019 not proved.</p>
2b	<p><i>not grading for quality the OPG (panoramic) radiographs taken on 12 October 2016 and/or 23 January 2019,</i></p> <p>Found Proved</p> <p>The Committee considered Mr Kidner's report in which he stated that there was no record of the grading of these radiographs in the clinical records. He confirmed in his oral evidence that grading stating whether the radiograph was satisfactory or unsatisfactory should be provided either on the images or in the clinical notes, but that it was not present on either in this case. The Committee also considered the clinical records, including two images that are undated but are inferred to be 12 October 2016 and the dated radiograph of 23 January 2019, but could not find any evidence of grading on the radiographs themselves or in the notes. The Committee accepted the opinion of the expert that the radiographs were not graded for quality, should have been graded and that Mr Iwanicki failed to maintain an adequate standard of record keeping in respect of not grading for quality radiographs taken on 12 October 2016 and 23 January 2019. It therefore found this charge proved.</p>
2c	<p><i>not reporting on the OPG (panoramic) radiographs taken on 12 October 2016 and/or 23 January 2019.</i></p> <p>Found Proved</p> <p>The Committee noted that having been amended at this hearing, this charge only related to 12 October 2016. It noted the opinion of Mr Kidner in his report that 'a report of findings from the images have not been recorded in patient 1's records'. Mr Kidner confirmed this opinion in his oral evidence, in which he stated that he would expect a report based on OPG radiographs to be in the patient's clinical notes, but that this appeared to be absent. The Committee also considered the clinical records provided to it and found no evidence of a report relating to the radiographs. The Committee therefore in accepting the expert's opinion and from its own evaluation of the clinical records, concluded that this charge was found proved.</p>



<p>2d</p>	<p><i>The handwriting is difficult to interpret and contains words and abbreviations which are indecipherable</i></p> <p>Found Proved</p> <p>The Committee considered the expert's oral and written evidence in relation to this charge. It noted that the expert had stated that <i>'the hand-written notes are difficult to interpret and some words and abbreviations were indecipherable'</i> and that this <i>'fell far below the expected standard for record keeping'</i>. The Committee relied upon the expert's opinions that Mr Iwanicki used markings and abbreviations in his notes that were unclear and not standard in clinical notes. The Committee also took into account Mr Kidner's oral evidence in which he stated that in the numerical references in the notes, Mr Iwanicki could have been referring to wires or other orthodontic parts, but that this was not standard language. He stated that there is an expectation for dental professionals to use language that another practitioner could understand.</p> <p>The Committee noted that the expert had provided examples in his report but that these were only snapshots between 2017 and 2018. The Committee reviewed and took into account the clinical records for the whole period of this charge. It agreed that the records were difficult to interpret. The Committee accepted Mr Kidner's opinion from his oral and written evidence, and from its own assessment of the clinical records, found this charge proved.</p>
<p>3</p>	<p><i>You failed to retain adequately or at all, the dental records in respect to Patient 1's appointments from 14 September 2016 to 06 May 2021 including:-</i></p>
<p>3a</p>	<p><i>treatment between 06 December 2016 and 09 November 2017;</i></p> <p>Found Proved</p> <p>The Committee considered the report provided by Mr Kidner. This report noted that <i>'The record of treatment between 06/12/2016 and 09/11/2017 is completely missing'</i>. The Committee wished to clarify with the expert in his oral evidence how he knew that there would have been treatment during this time. Mr Kidner clarified in oral evidence that there would have been treatments during this period, such as adjustments to braces and check-ups. His expert opinion was that these would have happened every 6-8 weeks and that even if the patient had been seen at another practice or by another clinician, there is an expectation that the clinical records would have been updated with this information. The Committee accepted Mr Kidner's opinion that appointments would have taken place during this time and that records should have been retained of these.</p> <p>The Committee noted the correspondence between Patient 1 and the Practice regarding the cancellation of appointments by Mr Iwanicki between June and October 2017. Nonetheless, the Committee having regard to the expert's opinion that adjustment appointments would have been carried out every 6-8 weeks, concluded that on the balance of probabilities there must have been at least one or two appointments between 6 December 2016 and the first cancelled appointment of 23 June 2017. It concluded that the treatment records of these have not been adequately retained, and accordingly found this charge proved.</p>

3b	<p><i>photographs taken on 14 September 2016 and/or 13 February 2018 and/or 11 September 2018;</i></p> <p>Found Proved</p> <p>In its own review of the clinical records, the Committee noted that there is only one photo of Patient 1's teeth, dated February 2019, but that this does not relate to any of the clinical records stating that photos have been taken. It noted that on 14 September 2016 there is a record of photos being taken, on 13 February 2018 it is noted '<i>foto 3x</i>', and on 11 September 2018 it is also noted '<i>foto 3x</i>', suggesting that 3 photos were taken of the teeth. The Committee took into account the email to Patient 2 from Mr Iwanicki in which he stated that he didn't consider all photos to be medical records, that he took and kept some photos for his own purposes, and deleted others.</p> <p>The Committee also had regard to the expert's oral evidence that any photos taken of a patient's teeth, should be considered as medical records and therefore should have been retained in the clinical notes. The Committee accepted the expert's opinion. Further the Committee noted that Mr Iwanicki documented taking the photos in the notes, which the Committee considered indicated clinical relevance.</p> <p>The Committee therefore determined that these images should have been retained, and accordingly finds this charge proved.</p>
3c	<p><i>the study models from 12 October 2016;</i></p> <p>Found Not Proved</p> <p>The Committee noted that the expert's report stated that 'the study model records from 12/10/2016 are missing'. The Committee accepted that the models were not provided to the expert but did not consider this determinative of the allegation that Mr Iwanicki failed to retain the study models. The Committee made the observation that the models by their nature would not necessarily be stored with the written records. It concluded that the determination of whether the models were missing was not a matter of opinion, but a matter of fact for the GDC to prove.</p> <p>The Committee therefore turned to the factual evidence and considered Witness A's statement in which he described the storage procedure and stated that he believed Mr Iwanicki had some of the models in Poland. He stated that '<i>I think the Registrant was using laboratories in Poland and therefore some models were taken to Poland with him. I managed to locate some files on one of my backup media from reception computers showing the postal proof to Poland with the name of the laboratory, and I found an email from UK lab for Patient 1's (sic) retainer.</i>'</p> <p>The Committee did not consider this evidence proved that the models had not been retained adequately or at all, given that they may have been in Poland. The Committee considered that it may have been adequate to retain them in Poland, if such retention was secure. There was no evidence before the Committee that any study models had been destroyed or not adequately retained, only that they may have been in Poland.</p>

	<p>Further, the Committee considered the email from Patient 1 to the Practice dated 7 February 2018 asking for '<i>casts, photos, brackets and whatever is necessary for my treatment</i>' and noted that the reply from the practice was that the patient could come and collect these from the reception.</p> <p>The Committee bore in mind that the burden of proof was on the GDC to prove that Mr Iwanicki had not retained the study models adequately or at all.</p> <p>Given that the possibility that they were being retained in Poland, or collected by Patient 1, the Committee found this charge not proved.</p>
Patient 2	
4	<i>You failed to provide an adequate standard of care to Patient 2 in that:</i>
4a	<p><i>the brackets on the lower incisors are poorly positioned;</i></p> <p>Found Proved</p> <p>The Committee noted that the expert's opinion in his report was that '<i>the brackets on the lower teeth are positioned too close to the gingival margins which will make cleaning very difficult and so contributed the gum problems that patient 2 experienced</i>'. Mr Kidner reiterated this point in his oral evidence, and also stated that the gums look swollen and inflamed in the photos provided. The Committee accepted Mr Kidner's opinion. The Committee accordingly found this charge proved that Mr Iwanicki failed to provide an adequate standard of care in that the brackets on the lower incisors were poorly positioned.</p>
4b	<p><i>the outcome of the upper arch treatment was poor</i></p> <p>Found Proved</p> <p>The Committee considered the expert's report in which he stated that '<i>The upper dental arch is not level</i>'. The Committee noted that the photos provided alongside this opinion sufficiently supported the expert's opinions. The Committee accepted Dr Kidner's opinions that this treatment outcome was poor, contributing to a failure to provide an adequate standard of care and accordingly found this charge proved.</p>
5	<i>You failed to maintain an adequate standard of record keeping in respect of Patient 2's appointments from 31 March 2016 to 18 January 2017 in respect of:</i>
5a	<p><i>The records are handwritten and difficult to decipher.</i></p> <p>Found Not Proved</p> <p>In considering this charge, the Committee had particular regard to the clinical records and the expert's report.</p> <p>It noted that the expert's report provided examples of handwritten notes that he opined were difficult to decipher, however the Committee observed that only the last record in this example fell within the correct date span of this charge. The Committee also noted that the handwriting appeared to be different on the date of this final note in the expert's example. The Committee went on to assess the</p>

	<p>records themselves. It considered that the expert's opinion focused on earlier records and not the ones relevant to this charge, and therefore did not accept the opinion of Mr Kidner in relation to this charge.</p> <p>The Committee having regard to the clinical notes for the date span in this charge, noted that they were handwritten however did not deem that they were hard to decipher. It also noted that there appeared to be different handwriting under different initials on some entries within this date range that were difficult to read, and therefore was not persuaded that these were written by Mr Iwanicki.</p> <p>The Committee therefore found this charge not proved.</p>
6	<i>You failed to retain adequately or at all, the dental records in respect to Patient 2's appointments in respect to:-</i>
6a	<p><i>Clinical photographs taken on 09 December 2015;</i></p> <p>Found proved</p> <p>The Committee first noted that irrespective of Mr Iwanicki's statements to the Practice and to patients that many of the photos taken did not count as clinical records, the expert opined that photos taken would be medical records and the Committee accepted this opinion.</p> <p>It noted that there was a record in the clinical notes of photos having been taken on this date, and therefore they should have been retained within the clinical notes.</p> <p>It next considered the records and noted that there was no evidence of these photos in the clinical records provided to it. The Committee noted that Mr Iwanicki had stated that he deleted many of the photos taken because they were out of focus or no longer relevant. The Committee also noted that in the letter from Mr Iwanicki to patient 2 dated 30 May 2017, he states that some photographs were not retained because they were not medical records. On the basis of the expert evidence and its own analysis of the records, the Committee finds this charge proved.</p>
6b	<p><i>Clinical photographs taken on 31 March 2016;</i></p> <p>Found proved</p> <p>This charge is found proved for the same reasons as in 6a above.</p>
6c	<p><i>Clinical photographs taken on 14 September 2016.</i></p> <p>Found proved</p> <p>The Committee noted from the clinical records that three photos were taken on this date as it is noted 'Foto 3x'. However, it noted that there are no photos in the clinical records that are directly indicated to have been taken on this date. It notes that the expert refers to four photos that in his opinion were taken around this date due to the stage of this treatment. The Committee noted that there were four photos in the records, whilst the clinical notes only refer to three.</p> <p>The Committee noted that the photos suggested by the expert to be dated around 14 September 2016, do not show the patient to have an upper brace in</p>

	<p>place. In assessing the clinical notes, the Committee noted that there is a record from 1 March 2017 that at the next appointment there would be <i>'debonding of the upper arch'</i>, suggesting that an upper brace was still in place.</p> <p>The Committee concluded that it was not possible to determine whether the four undated photos are the photos taken on 14 September 2016, or whether there are no copies at all of the photos recorded in the clinical notes. The Committee therefore found proved that the photos from 14 September 2016, had not been retained adequately, or possibly at all, given that there is no indication of a date on the four photos in the records. It accordingly found this charge proved.</p>
6d	<p><i>All treatment undertaken in Poland during the course of orthodontic treatment</i></p> <p>Found Proved</p> <p>The Committee noted the evidence that Patient 2 repeatedly asked Mr Iwanicki to provide the records of her treatment in Poland.</p> <p>The Committee considered the emails provided alongside the clinical records relating to Patient 2's request for these records. Mr Iwanicki stated in one email dated 21 March 2017 to the Practice that <i>'As for the documentation of the course of the treatment, is the patient referring to the card on which I made notes of the respective visits? That's something we haven't discussed, and that's something I haven't looked for at all yet. The card with visits in London is at your place. I don't even know where to look for the card from Poland. I have a computer from my practice in Poland but no physical cards. I have had more than 2,000 patients. If I were to keep them all, I would have to rent some large room for this purpose'</i>. The Committee considered this indicates inadequate retention of the records of Patient 2's treatment in Poland.</p> <p>The Committee accepted the expert's opinion that records of treatment in Poland were missing from the clinical records, that these records should be included in Patient 2's treatment record and that the failure to retain them adequately or at all amounts to a failure to retain adequately or at all, the dental records in respect to Patient 2's appointments.</p> <p>On the basis of the communication from Mr Iwanicki in response to Patient 2's requests, the treatment records provided, and the expert evidence, the Committee found this proved.</p>
6e	<p><i>The removal of the braces after 18 January 2017</i></p> <p>Found Proved</p> <p>The Committee had regard to the expert opinion and the clinical record provided. The Committee firstly noted that the records note the date of the relevant appointment as 18 January 2016, but given the order of dates in the notes it has concluded that this was likely an error and that this note was made on 18 January 2017.</p> <p>The Committee carefully assessed the clinical records. The Committee noted that they had been provided with photos of the Patient's teeth in which the upper brace had been removed, however it could see no note in the clinical records of when this took place or by whom. Mr Kidner in his written and oral evidence also gave this view. The Committee accepted this opinion.</p>

	<p>The Committee was satisfied that there were no retained records about the removal of the braces and therefore it found this charge proved.</p>
6f	<p><i>You deleted clinical photographs of Patient 2.</i></p> <p>Found Proved</p> <p>The Committee noted that Mr Iwanicki had stated in an email to the Practice on 21 March 2017 that he had deleted any photos that he did as he did not deem them to be medical evidence. The Committee also noted the letter from Mr Iwanicki to Patient 2 on 30 May 2017 in which he stated that he had deleted the photos taken. He stated <i>'Photographs taken with my private camera or phone did not constitute medical records because they are not standardized in any way. They were made exclusively for my use, so that I could remember a particular patient, the current stage of treatment, plan further dental shifts, possibly capture a medical situation that is interesting from my point of view and use it, for example, in publications. The photographs that do not meet these conditions or are older are permanently deleted'</i>.</p> <p>On the basis of this correspondence, the Committee determined that Mr Iwanicki did delete photographs and there was a failure to retain adequately or at all the dental record. Accordingly it finds this charge proved.</p>
7	<p><i>You failed to provide Patient 2 with a copy of their clinical records when requested.</i></p> <p>Found Proved</p> <p>The Committee took into account the emails provided to it from Patient 2 dated 23 April 2017 and 15 May 2017 in which they requested their records. It noted that in the email of 14 May 2025, Patient 2 writes <i>'I am also asking you to send me the medical records – discharge documents from Wroclaw which I had asked you to do several times and I still haven't received them. As a patient I have the right to see the medical records.'</i></p> <p>The Committee considered the response from Mr Iwanicki dated 30 May 2017, in which he stated that he had deleted the photos of their teeth as he had not considered them to be medical records and that the model had most likely been destroyed.</p> <p>Given this evidence, the Committee determined that Mr Iwanicki failed to return copies of Patient 2's clinical records as requested. Accordingly, it found this charge proved.</p>
8	<p><i>You failed to provide the Practice with a copy of Patient 2's clinical records when requested.</i></p> <p>Found Proved</p> <p>The Committee having found charge 7 proved, was satisfied that Patient 2 had requested a copy of their records through the Practice and therefore Mr Iwanicki did not provide these to the registrant nor the Practice. The Committee noted the email from Patient 2 on 23 April 2017 requesting a copy of their records, and the email from the practice dated 24 April 2017 forwarding this request to Mr</p>

	<p>Iwanicki. The Committee further noted the email from Mr Iwanicki dated 3 April 20218 to the Practice discussing the outstanding invoice he was owed and stating <i>'As I mentioned earlier, settling this invoice is necessary to gain access to missing patient records'</i>. The Committee accepted the evidence of Witness A believed that the requests for the records had not been responded to by Mr Iwanicki.</p> <p>Mr Kidner opined that there had a been a failure to respond to the practice as they had been forwarding requests from the patient and Mr Iwanicki did not provide documents when requested.</p> <p>The Committee considered the email from the Practice Manager dated 8 April 2018 in which he stated <i>'I now trust you will do all what is necessary to release and return ALL patient data and models in an effective and urgent manner'</i>. The Committee noted that there was no further correspondence provided that suggest the records were returned in this manner and was satisfied that they had been requested but not provided to the Practice.</p> <p>The Committee found this charge proved.</p>
9	<p><i>From 22 June 2021 to present, you failed to co-operate with the GDC in that you did not:</i></p>
9a	<p><i>Maintain up to date contact details;</i></p> <p>Found Proved</p> <p>The Committee particularly took the witness statements of GDC Registrations Officer Sonia Sowan and GDC Paralegal Ashley Maswodza and related exhibits into account. It noted that their evidence was produced in the course of their professional work and considered it to be reliable. It noted from Ms Sowan's evidence that Mr Iwanicki last updated his email address with the GDC on 3 February 2019. It further noted that, on Mr Maswodza's evidence that emails on and after 7 June 2021 to Mr Iwanicki's registered email address were returned as undelivered, the receipt stating that the email address did not exist.</p> <p>Mr Maswodza also stated that on 9 June 2021 that the home phone number was called and found to be invalid. In December 2024, Mr Iwanicki emailed the GDC via an online enquiry form using a different email address, although he did not update his registered details. From at least November 2025, emails to this alternative email address have been also returned, stating the email address does not exist. Post sent to Mr Iwanicki's registered postal address on 17 December 2025 was also returned as undelivered. The Committee noted that the charge in particular relates to the period from 22 June 2021 to present. The Committee is satisfied from the evidence of Ms Sowan and Mr Maswodza that Mr Iwanicki had failed to maintain up to date contact details throughout this period, and that this amounts to a failure to cooperate with the GDC. The Committee determined that this charge was found proved.</p>
9b	<p><i>Respond to communications sent by the GDC.</i></p> <p>Found Proved</p> <p>The Committee considered the witness statement provided by Ashley Maswodza of the GDC. It noted that there had been multiple occasions in which</p>

Mr Iwanicki had been contacted to which there had been no response. There appeared to be no evidence that Mr Iwanicki had corresponded with the GDC since 2024. It also noted that emails sent to both registered email addresses for Mr Iwanicki would be noted as undeliverable, suggesting that these were no longer valid email addresses, despite communication from these previously. The Committee was satisfied that the witness statement, made in the witness' professional capacity, was reliable and that the evidence provided sufficiently proved that Mr Iwanicki had failed to co-operate with the GDC by not responding. It therefore finds this charge proved.

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

41. We move to stage two.

Stage 2 Determination

42. Following its announcement of its decision on the facts, the hearing moved to Stage 2. At Stage 2, the Committee considered whether the facts found proved amounted to misconduct and, if so, whether Mr Iwanicki's fitness to practise is currently impaired by reason of his misconduct. If it found that Mr Iwanicki's fitness to practise is impaired, it would consider what sanction, if any, should be imposed.

Evidence at stage two

43. The Committee received a further bundle from the GDC at this second stage of the hearing. This bundle had information relating to Mr Iwanicki's fitness to practise history including four previous Professional Conduct Committee determinations.

Submissions

44. Mr Saad first addressed the Committee in respect of Mr Iwanicki's fitness to practise history. He submitted that Mr Iwanicki had been subject to a substantive hearing in January 2021 for allegations of clinical failings in relation to a different patient. He confirmed that this resulted in a 6 month suspension with a review. Mr Saad submitted that at this previous substantive hearing, Mr Iwanicki had not been present or represented. He submitted that the adverse findings at this hearing included, but were not limited to, inadequate orthodontic assessments, not providing justification of OPG radiographs, not discussing risks and benefits of treatments with the patient, not having an adequate treatment plan, poor standard of treatments in his positioning of brackets, record keeping failings, and a failure to obtain informed consent. Mr Saad submitted that the Committee had found that Mr Iwanicki was impaired by reason of his misconduct and that there were failings across many fundamental areas of dentistry. Mr Saad submitted that the facts found proved at this previous hearing, were of similar nature to the facts found proved at this substantive hearing.

45. Mr Saad submitted that the previous substantive case had been reviewed three times since the initial sanction of a 6 month suspension with a review. In July 2021, it was extended for a further 12 months, and in July 2022, it was extended for a further 9 months. Mr Saad also submitted at this point that Mr Iwanicki had attended the review in July 2022 but that he had stated that he no longer wishes to practice as a dentist and had not provided any relevant CPD or remediation. In March 2023 the sanction was changed to an indefinite suspension. The

Committee in March 2023 determined that Mr Iwanicki had been given sufficient time and opportunities to remediate his practice however he had not done so.

46. With regard to misconduct, Mr Saad referred the Committee to the relevant case law and the GDC's *Standards for the Dental Team (2013)*.
47. Mr Saad submitted that this case related to multiple failures in diagnostic practice, a poor standard of care, record keeping, and failures in cooperation with the GDC. Mr Saad submitted that Mr Kidner had identified that Mr Iwanicki's practice fell below the standard expected of a registered dentist in his treatment of Patient 1 and Patient 2. Mr Saad therefore submitted that Mr Iwanicki's conduct was in breach of Standards 1, 4, 6, and 9 and that the facts found proved therefore amounted to misconduct.
48. Mr Saad moved on to the issue of current impairment. He referred to the relevant case law, and submitted that impairment can be considered in two parts: the public protection component and the public interest component.
49. Mr Saad submitted that there had been multiple failings at all aspects of the allegations by Mr Iwanicki. He submitted that there was evidence of risk to the public given that Mr Iwanicki had not provided any evidence of addressing any of the risks. He submitted that Mr Iwanicki had not targeted any of the failings in the time elapsed since the allegations came to light. Mr Saad also submitted that on 20 December 2024, Mr Iwanicki had requested removal from the dental register which suggested a longstanding desire to move away from the profession. Mr Saad therefore submitted that there was a real risk to the public and therefore Mr Iwanicki was currently impaired on public protection grounds.
50. Mr Saad also considered the public interest component to current impairment. He submitted that given the breadth of failings over a long period of time, and Mr Iwanicki's ongoing non-cooperation with the GDC, that he is currently impaired. He submitted that a finding of current impairment was necessary to maintain public confidence in the dental profession.
51. Mr Saad lastly addressed the Committee on the matter of sanction. He submitted that the Committee must consider proportionality and consider the range of sanctions available to it. Mr Saad provided no mitigating factors for the Committee to consider in this case. He however submitted that there were aggravating factors to be considered, these being:
- There was an actual risk of harm to Patient 2 in that the poor standard of clinical treatment led to gum problems and that Patient 2 requested copies of their dental records multiple time to no avail;
 - The misconduct was sustained and repeated, in that the charges related to two patients over a fairly significant charge period;
 - There is a blatant and wilful disregard to the regulator in Mr Iwanicki's non-cooperation with the GDC;
 - There is an adverse fitness to practise history, and that Mr Iwanicki is already indefinitely suspended for allegations that overlap with the allegation at this hearing. There has been extremely little engagement since either of these allegation came to light;
 - There is a lack of insight by Mr Iwanicki- he has provided no insight or remediation in relation to the allegations against him at either fitness to practise case. Even when he did attend the review of July 2022, he did not show any insight or provide any remediation.
52. Mr Saad submitted that a reprimand would be an insufficient sanction as the allegations found proved were not at the lower end of the scale of seriousness. He submitted that this was not an

isolated incident, there was evidence of adverse fitness to practise history, and there was no evidence of any corrective steps Mr Iwanicki may have taken.

53. Mr Saad submitted that conditions could work given that the concerns in this case were mainly clinical. However, he submitted that conditions require engagement to be workable, and the committee has found proved that Mr Iwanicki has not been cooperating with the GDC. Therefore, a sanction of conditions was not appropriate.
54. Mr Saad submitted that a sanction of suspension was also inappropriate and insufficient given the aggravating factors. He submitted that the Committee should consider the guidance, and note that there has been no insight shown and that there are deep seated attitudinal problems in this case, which fall in line with requirements for the sanction of erasure.
55. Mr Saad therefore submitted that the appropriate sanction was erasure. He submitted that Mr Iwanicki had refused to provide medical records when requested and that he has completely disengaged from the GDC, his regulator. He submitted that these were evidence of an attitudinal problem on Mr Iwanicki's behalf. Mr Saad submitted that there had been a departure from the relevant professional standards in Mr Iwanicki's practice. He submitted that there was a continuing risk of serious harm, and was no evidence of the risks having been addressed, and a persistent lack of insight. Mr Saad submitted that Mr Iwanicki was already indefinitely suspended for similar behaviour and had been given the benefit by previous committees of suggestions on how to remediate his actions, but that he had not taken any action. Given these factors, Mr Saad submitted that a lesser sanction was not sufficient in the public interest and that a sanction of erasure should be imposed upon Mr Iwanicki.

Committee's Decision

56. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's Guidance document, '*Fitness to Practise: Guidance for the practice committees*' (6 January 2026) (the GDC's Guidance) and the relevant case law. The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

57. The Committee first considered whether the facts found proved amounted to misconduct. In doing so, the Committee had regard to the GDC's publication, *Standards for the dental team* (September 2013).
58. The Committee in its regard to the GDC standards noted that principles 1, 4, 6 and 9 were relevant to the facts found proved. It considered the standards at principle 1 (Put patients' interests first) and 6 (Work with colleagues in a way that is in patients' best interests) to be applicable. It also considered to be applicable the following standards at principles 4 (Maintain and protect patients' information) and 9 (Make sure your personal behavior maintains patients' confidence in you and the dental profession):
- Standard 4.1- You must make and keep contemporaneous, complete and accurate patient records
 - Standard 4.4- You must ensure that patients can have access to their records
 - Standard 9.4- You must co-operate with any relevant formal or informal inquiry and give full and truthful information

59. The Committee considered that Mr Iwanicki had breached the standards of dentistry as set out above. It noted that the expert witness had confirmed in both oral and written evidence that Mr Iwanicki's care fell far below the standard expected of a dental professional in relation to the proven clinical charges at 1-8 relating to diagnostic practice, record keeping, retention of records, standard of care, and providing records when requested.
60. Some of Mr Iwanicki's clinical failings were interwoven with attitudinal issues in that it appeared at times Mr Iwanicki considered that relevant professional expectations, such as retaining patient records and enabling appropriate access to them, did not apply to him. The Committee considered the clinical failings, some with associated attitudinal issues, were serious, would be considered deplorable by fellow practitioners and amounted to misconduct.
61. The Committee also considered that the facts found proved at charge 9 in relation to cooperation with the GDC breached the GDC's standards as Mr Iwanicki's blatant disregard of his regulator is serious with implications for patient safety. Professional regulation exists to safeguard patients and uphold public confidence. Mr Iwanicki's systematic failure to liaise and cooperate with his regulator undermines these objectives. The Committee considered that this repeated non-compliance was serious and amounted to misconduct. As a result, the Committee determined that all the facts found proved amounted to misconduct.

Impairment

62. The Committee then considered whether Mr Iwanicki's fitness to practise is currently impaired by reason of his misconduct on the grounds of the protection of patients and/or is in the wider public interest.
63. The Committee considered whether Mr Iwanicki's fitness to practise was impaired on public protection grounds. It considered whether the misconduct found was remediable and concluded that since 8 out of the 9 the charges related to clinical concerns, these could be remediated by retraining and appropriate CPD. However, the Committee has observed an attitudinal issue underpinning some of the clinical issues and this is more difficult to remediate. Though attitudinal, the last charge relating to non-cooperation with the GDC could, in theory, be remediated by effective reflection and engaging with the GDC. However, the committee noted that despite this being possible, there is no evidence that Mr Iwanicki has undertaken any reflection, taken any remedial action, or acted upon the advice of previous Professional Conduct Committees in relation to remediation. He has also stated that he no longer wishes to continue in dentistry.
64. This Committee was satisfied that the lack of willingness to remediate his actions and the fact that he now had two cases in which facts were found proved for similar clinical concerns, suggested a high likelihood that Mr Iwanicki would repeat the conduct should he practise with no restriction in place. It also considered that Mr Iwanicki's conduct in the facts found proved at this hearing had likely led to some harm to Patient 2, arising from inadequate care. The Committee was satisfied that there was evidence of an ongoing risk of harm to patients and given the risk of repetition, concluded that Mr Iwanicki's practise poses a real risk of harm to patient safety and therefore he is currently impaired on public protection grounds.
65. The Committee next considered whether a finding of impairment by reason of Mr Iwanicki's misconduct was necessary within the wider public interest. The Committee considered that the charges found proved were serious, involving multiple clinical failings, and attitudinal problems. The Committee noted that there were repeated and flagrant breaches of GDC standards in relation to record keeping, the retention of records, as well as cooperation with the GDC. The Committee also took into account that Mr Iwanicki already has similar findings relating to his clinical practice, which have not been remediated. It determined that an informed member of the public would be shocked and troubled should no finding of impairment be made in circumstances where serious clinical failings have been found and Mr Iwanicki's non-cooperation is ongoing.

66. The Committee therefore determined that a finding of impairment was required to maintain public confidence in the profession and to declare and uphold proper professional standards of conduct and behaviour. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made. The Committee therefore found that Mr Iwanicki's fitness to practise is currently impaired by reason of his misconduct on wider public interest grounds of maintaining public confidence and upholding professional standards.

67. Accordingly, the Committee has determined that Mr Iwanicki's fitness to practise is currently impaired both on the grounds of protection of the public and the wider public interest.

Sanction

68. The Committee next considered what sanction, if any, to impose on Mr Iwanicki's registration. It recognised that the purpose of a sanction is not to be punitive although it may have that effect. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the GDC's Guidance.

69. The Committee considered the mitigating and aggravating factors in this case and took into consideration the relevant paragraphs in the GDC's Guidance on these matters.

70. The Committee considered that there were no mitigating factors in this case.

71. The aggravating factors in this case were that:

- There was a risk of harm in Mr Iwanicki's treatment of Patients 1 and 2;
- The misconduct was repeated over a significant period of time;
- Mr Iwanicki showed a blatant disregard of the GDC and the systems regulating the profession in his non-cooperation and disengagement with the GDC;
- Mr Iwanicki has an adverse fitness to practise history with the GDC and is currently indefinitely suspended for clinical concerns of a similar nature;
- Mr Iwanicki has shown a lack of insight, in that he has not engaged with the investigation and therefore not provided any evidence of insight into his conduct.

72. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest nor adequately protect the public given the seriousness of the misconduct found proved and its attitudinal aspect.

73. The Committee considered a sanction of a reprimand, however it deemed that the conduct was too serious and that there was no evidence that a reprimand would be in any way effective, given Mr Iwanicki's disregard for the regulatory process and the absence of remediation.

74. The Committee next considered a sanction of conditions. The Committee reminded itself that conditions were only suitable and proportionate when it could be confident that a registrant may comply. The Committee noted that Mr Iwanicki has disengaged from the process, and stated that he does not wish to practice within dentistry, and therefore a sanction of conditions would not be workable. The Committee also noted that there were attitudinal issues in Mr Iwanicki's conduct which cannot be appropriately managed by a sanction of conditions. The Committee therefore concluded that a sanction of conditions was not sufficient.

75. The Committee went on to consider whether to suspend Mr Iwanicki's registration for a specified period up to a maximum 12 months. It had regard to paragraph 277 of the Guidance, which states that:

“Suspension may be appropriate when all, or some, of the following factors are present:

- a. There is evidence of repetition of the behaviour.*
- b. The registrant has not shown insight into the issues which led to a finding of current impairment being made, and/or poses a significant risk of repeating the behaviour.*
- c. A lesser sanction would be insufficient to meet the public interest.*
- d. There is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)”.*

76. The Committee noted that some of the factors from paragraph 277 of the Guidance apply in this case, particularly the lack of insight, the risk of repetition and that a lesser sanction would be insufficient to meet the public interest. However, the Committee’s view was that Mr Iwanicki’s disengagement from the process and the lack of evidence of insight that comes alongside this, and the proven misconduct of non-cooperation with the GDC and issues related to the retention and provision of records, indicated a deep-seated professional attitudinal problem. It noted that in 2024, Mr Iwanicki had stated that he wants to leave dentistry and there was no evidence of any desire or intention to remediate the issues in this case.
77. The Committee considered that Mr Iwanicki had breached fundamental tenets of the profession by showing a blatant disregard for his obligation to retain adequate patient records and for his obligation to interact with his regulator. Both of these obligations exist to protect patients and Mr Iwanicki has repeatedly demonstrated an unwillingness to comply with them. The Committee noted from the Guidance that harmful deep-seated or professional attitudinal problems might make erasure the appropriate order. Therefore, it had regard to paragraph 282 of the Guidance, which deals with erasure. The Committee considered that a number of factors indicating erasure are present in this case. In particular, it noted:
- The findings include serious departure(s) from the relevant professional standards.
 - Mr Iwanicki has shown a persistent lack of insight into the seriousness of actions or their consequences.
 - A lesser sanction would be insufficient to meet the public interest.
78. Given the presence of these factors from paragraph 282 of the Guidance, and its serious concerns about Mr Iwanicki’s professional attitude and clinical failings, the Committee concluded that the suspension of his registration would not be sufficient to uphold the wider public interest or to protect the public.
79. In the Committee’s judgement, Mr Iwanicki’s deep seated attitudinal problem and his failure to engage meaningfully with the GDC’s process combined with the clinical failings, and lack of insight and remediation, represents conduct that is fundamentally incompatible with continued registration.
80. In all the circumstances, the Committee determined that the only appropriate and proportionate sanction in this case is one of erasure. In imposing this highest sanction, the Committee was satisfied that the need to protect the public and the wider public interest outweighed Mr Iwanicki’s own interests.
81. Unless Mr Iwanicki exercises his right of appeal, his name will be erased from the Dental Register, 28 days from the date that notice of this Committee’s determination is deemed to have been served upon him.
82. The Committee next invited submissions from Mr Saad, as to whether an immediate order of suspension should be imposed on Mr Iwanicki’s registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for suspension.

Decision on an immediate order

83. Mr Saad made an application for an immediate suspension order to be imposed on Mr Iwanicki's registration under Section 30 of the Dentists Act 1984 (as amended). He submitted that an immediate order for suspension is necessary for the protection of the public and is otherwise in the public interest. He submitted that the Committee had found that there was a real risk of harm to patient safety and that it had at the earlier stage determined that an informed member of the public would be troubled should no sanction be imposed. He took the Committee to the Guidance, specifically paragraph 288 which refers to immediate orders. He submitted that all three factors in which the guidance indicates an immediate order may be necessary were applicable. These were that the registrant's behaviour is considered to pose a risk, the registrant has placed patients at risk through poor clinical care, and immediate action is required to maintain public confidence in the professions.
84. Mr Saad submitted that this was a peculiar case as Mr Iwanicki is already subject to an indefinite suspension. He submitted however that an immediate order was necessary because Mr Iwanicki could theoretically submit an appeal in the next 28 days, and simultaneously apply for a review of the immediate suspension currently in place, at which a Committee could deem that the suspension was no longer necessary. Mr Saad submitted that if this were to happen, it could frustrate the process. He therefore submitted that an immediate order was necessary to protect patient safety.
85. The Committee accepted the advice of the Legal Adviser, who drew its attention to the relevant guidance contained in the GDC's Fitness to Practise: Guidance for the practice committees (January 2026).
86. The Committee considered whether an immediate order was necessary on both the ground of public protection and the wider public interest grounds. The Committee considered that Mr Iwanicki is already under a direction of indefinite suspension and that a reviewing Professional Conduct Committee would have to be satisfied that he no longer posed a risk to amend this sanction. The Committee was satisfied that any reviewing Committee would receive notice of the decision and facts of this case, and that in its review it would have to consider these matters.
87. Therefore, the Committee was satisfied that the public was adequately protected by the fact that Mr Iwanicki would only be able to practise during an appeal period if permitted by a fully informed Professional Conduct Committee having undertaken a comprehensive assessment of his fitness to practise. The Committee therefore concluded that the threshold of necessity was not met in regards to the issue of public protection.
88. The Committee considered whether an immediate order was necessary solely in the wider public interest of maintaining public confidence and professional standards. It did not consider that the facts of this case necessitated such an order, particularly in light of the indefinite suspension.
89. The Committee therefore determined that the threshold for the imposition of an immediate order was not met and therefore did not impose such an order.
90. Unless Mr Iwanicki exercises his right of appeal, the substantive direction for erasure will take effect 28 days from the date of deemed service.
91. That concludes this determination.

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