

PUBLIC HEARING**Professional Conduct Committee
Initial Hearing****6 – 9 October 2025****Name:** CANDELIERE, Francesco**Registration number:** 255710**Case number:** CAS-208545-M1X6K9

General Dental Council: David Patience, Counsel.
Instructed by Rosie Geddes IHLPS**Registrant:** Present
Represented by Tom Day, Counsel.
Instructed by the MDU

Outcome: No case to answer

Committee members: Susan Stevens (Dentist (Chair))
Joanne Brindley (Dental Care Professional)
Jeannett Martin (Lay)**Legal adviser:** Melanie Swinnerton**Committee Secretary:** Andrew Keeling

CHARGE

Francesco CANDELIERE, a dentist, Dip Dent Chieti 2013, is summoned to appear before the Professional Conduct Committee on Monday, 6 October 2025, for an inquiry into the following charge:

“That being a registered dentist:

Patient B

1. *You failed to provide an adequate standard of care to Patient B at an appointment on 22 August 2022 including by:*
 - a. *Not adequately communicating the treatment plan to the patient*
 - b. *Not providing the patient with all the treatment options*
 - c. *Not discussing the risks and benefits of proposed treatment*
2. *You failed to obtain informed consent for treatment provided to Patient B on 22 August 2022.*
3. *You failed to communicate with Patient B and/or the responsible adult accompanying him in an adequate and/or appropriate manner at an appointment on 22 August 2022.*

Patient A

4. *You failed to provide an adequate standard of care to Patient A in that:*
 - a. *You did not verbally communicate the treatment plan to the patient, either adequately, or at all, at appointments on:*
 - i. *24 June 2021*
 - ii. *26 July 2021*
 - iii. *23 August 2021*
 - b. *You did not provide a written treatment plan to the patient at appointments on:*
 - i. *24 June 2021*
 - ii. *26 July 2021*
 - iii. *23 August 2021*

5. *You failed to obtain informed consent for treatment provided to Patient A at an appointment on:*
 - a. *23 August 2021*
6. *You failed to communicate with Patient A in an adequate and/or appropriate manner at appointments on:*
 - a. *24 June 2021*
 - b. *23 August 2021*

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

Mr Candeliere,

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct.
2. You were present at the hearing and represented by Mr Tom Day, Counsel. Mr David Patience, Counsel, appeared on behalf of the General Dental Council (GDC).
3. The hearing took place in person at the hearing suite of the Dental Professionals Hearing Service in Wimpole Street, London, between 6 and 9 October 2025.

Preliminary Matter

Rule 18 Application to Amend the Charge (6 October 2025)

4. At the outset of the hearing, Mr Patience made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules') to amend the charge.
5. Mr Patience submitted that the proposed amendment was to replace the initials of the patients mentioned in the charge with the anonymous terms, Patient A and Patient B. He submitted that this amendment would bring the charge in line with the GDC's regulations about the anonymisation of patients in any publicised determination.
6. Mr Day, on your behalf, submitted that he had no objection to the proposed amendment.

The Committee's decision on the Rule 18 application

7. The Committee accepted the advice of the Legal Adviser on the Rule 18 application.
8. The Committee was satisfied that the amendment could be made without injustice to either party. The Committee, therefore, acceded to Mr Patience's application to amend the charge.

Background

9. The allegations in this case stem from your treatment of two patients, Patient A and Patient B.
10. You saw Patient B at an appointment on 22 August 2022. Patient B was around seven years old at the time and he attended with his aunt. It is alleged by the GDC that whilst examining Patient B's teeth you removed one of his deciduous top teeth, which was wobbly, with your fingers and without obtaining proper consent. Patient B's aunt wrote

a complaint by email to the practice the following day and was invited to attend a meeting with the practice owner and a trainee dental nurse (Witness 2). At that meeting, Patient B's aunt stated that your removal of Patient B's tooth without consent had left him and her feeling traumatised.

11. In light of the concerns raised by Patient B's aunt, the GDC instructed an expert, Mr Geoffrey Bateman, to write a report on the treatment you provided. Based on the findings in Mr Bateman's report, the GDC raised allegations that you failed to provide an adequate standard of care to Patient B in that you failed to tell Patient B of your intention to remove the tooth (*'the treatment plan'*), you failed to provide him with treatment options and failed to discuss the risks and benefits. Further allegations were raised that you had failed to obtain informed consent for the treatment provided to Patient B or communicate with him or his aunt in an adequate or appropriate manner.
12. In an email to the GDC in respect of this allegation (*'Rule 4 comments'*), dated 17 December 2023, you stated that you were testing the mobility of Patient B's teeth and had unintentionally removed the tooth when you applied pressure to it. You described your actions as *'involuntary'*.
13. In respect of Patient A, you saw him at four appointments on 24 June 2021, 26 July 2021, 23 August 2021 and 25 August 2021. The clinical records for these appointments have been obtained by the GDC. These show that you examined Patient A at the first appointment, placed a filling in the UL5 at the second appointment, a filling in the LL7 and undertook a scale and polish at the third appointment. The fourth appointment was described as an emergency appointment in the notes, but Patient A disputes this, as he attended due to an issue from his third appointment that he felt needed to be resolved. However, there are no allegations raised by the GDC in respect of this appointment on 25 August 2021.
14. The GDC obtained a witness statement from Patient A, who alleged that that you did not communicate with him at all during these appointments and that you never gave him a treatment plan, either written or verbal, for the treatment he received. In light of this, it is alleged by the GDC that your conduct amounted to a failure to provide an adequate standard of care to Patient A. It is further alleged that you failed to obtain informed consent for the treatment on 23 August 2021 as Patient A did not appear to understand that he was receiving a filling on that occasion in addition to having his teeth cleaned.
15. At the appointment on 23 August 2021, Patient A further alleged that when his teeth were being cleaned part of his tooth had been chipped. He stated that this fell on his lower lip and was vacuumed up by the dental nurse. However, when Patient A attempted to discuss this with you, he stated that you appeared to have difficulties understanding him and were being *'evasive'*. The GDC, therefore, has alleged that you failed to communicate with Patient A in an adequate or appropriate manner at this appointment, and also on 24 June 2021 when you allegedly failed to communicate the treatment plan to him.

Evidence

16. As part of the GDC's case, the Committee received evidence which included the following witness statements and associated exhibits:

- Patient A, dated 3 February 2025;
- Witness 1, Dental Nurse, dated 7 January 2025; and
- Witness 2, Dental Nurse, dated 29 January 2025.

17. The Committee also heard oral evidence from Patient A and Witness 1.

18. The Committee received the dental records for Patients A and B, and your Rule 4 comments, dated 17 December 2023.

19. The Committee further received an expert report, dated 29 January 2025, from Mr Geoffrey Bateman, who also gave oral evidence.

Application for No Case to Answer under Rule 19(3) (7 - 9 October 2025)

20. At the conclusion of the GDC's case, Mr Day made a submission, on your behalf, that pursuant to Rule 19(3) of the Rules, there was no case for you to answer in respect of all the heads of charge.

21. The Committee received written submissions from both Mr Day and Mr Patience, and these were supplemented by their oral submissions.

Mr Day's Written Submissions

22. Mr Day submitted that in respect of Patient B (heads of charge 1 to 3 inclusive), your case is that the removal of Patient B's tooth was not intended but the unintended consequence of testing the mobility of an extremely loose tooth. He submitted that it is the GDC's case that the extraction was an intended outcome and therefore the heads of charge could only be found proven if the GDC could prove that the removal was deliberate. He submitted that there is no such evidence. On the contrary, he submitted that there is clear evidence that the extraction was not intended. He referred the Committee to your Rule 4 comments. He also referred to the evidence of Witness 1, your Dental Nurse present at the appointment, who confirmed that you had told her in the days or weeks after the incident in August 2022 that you had not intended to remove the tooth and that it was an accident.

23. In contrast, Mr Day submitted that Mr Bateman's interpretation of your Rule 4 comments should be disregarded as it is not evidence within his expertise. Furthermore, he submitted that even if there were such evidence to support the

allegations it is of such a *'tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence'*.

24. In conclusion, Mr Day submitted that if the removal of Patient B's tooth was not intentional then there can be no question of failures in heads of charge 1 to 3.
25. In respect of the heads of charge 4(a), 5 and 6 relating to Patient A, Mr Day submitted that Patient A's dental records demonstrate that you had a detailed discussion with him about the four options for treatment of the decay for UL5 and LL7. Furthermore, he submitted that there was compelling evidence that you verbally communicated the treatment plan to Patient A on 24 June 2021 and that Patient A attended further appointments with you on 26 July 2021 and 23 August 2021 having previously agreed to that treatment.
26. Mr Day submitted that the GDC relies entirely upon Patient A's account alone. He submitted that Patient A's evidence stands in stark contrast to the records, the evidence of Witness 1 who stated that you would as a matter of routine discuss treatment options, risks/benefits and obtain consent from patients, and common sense. He submitted that the evidence of Patient A is of such *"a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence"* that the Committee should dismiss these allegations.
27. In respect of head of charge 4(b), Mr Day submitted that it is apparent that there are no signed treatment plans in Patient A's records. However, he submitted that the GDC is unable to prove that this amounted to a failure to provide an adequate standard of care. He submitted that the unchallenged evidence of Witness 1 was that the receptionist was tasked with this role. Furthermore, he submitted that even if the Committee was satisfied that there was a case to answer in respect of this allegation, no reasonable, properly directed Committee could find that the failure to provide a written treatment plan for two fillings over four years ago could be so serious that it could amount to misconduct.

Mr Patience's Written Submissions

28. Mr Patience, on behalf of the GDC, submitted that he conceded that in order for heads of charge 1 to 3 to be found proved, the Committee would have to be satisfied that it was more likely than not that you had intentionally removed Patient B's tooth, as opposed to it coming out accidentally. He submitted that the Committee could find the charges proved based on the following four pieces of evidence.
29. Firstly, he submitted that the clinical notes record an *'extraction'* of the tooth, which implies it was deliberately removed. He also submitted that there was no reference in the notes suggesting that the removal was unintentional.
30. Secondly, Mr Patience referred to Witness 1's unchallenged evidence and her descriptions of how you had taken out Patient A's tooth (*'took out'* or *'pulled...out'*) and

that it *'did not come out properly'*. He submitted that this indicated that your actions were intentional rather than accidental.

31. Thirdly, Mr Patience submitted that Patient B was significantly distressed by the removal of his tooth, and this in turn caused distress to his responsible adult. He submitted that this level of distress suggested that sufficient force was applied to the tooth at the point of removal to cause pain and indicated that the act was deliberate.
32. Lastly, Mr Patience submitted that your Rule 4 comments, when viewed overall, supported the GDC case more than your case as there was clear evidence within it that you admitted that your actions went beyond mobility testing.
33. In respect of the heads of charge 4(a), 5 and 6, Mr Patience conceded that the charges rest upon the written and oral evidence of Patient A. He submitted that the GDC now takes a neutral stance in respect of these allegations. However, he submitted two observations. Firstly, it does not follow that as Patient A booked future appointments that he would have been aware about the treatment he was to receive at those appointments. Secondly, he submitted that Patient A's annoyance after his final appointment with you and his failure to understand what that appointment was for, supported his account that he had very little communication from you about the treatment he was receiving.
34. In respect of head of charge 4(b), Mr Patience submitted that a properly directed Committee could find that no treatment plans were provided at these appointments as there are no treatment plans in the records. This is supported by the evidence of Patient A, who stated that he received no such plans, and the evidence of Witness 1 who outlined the usual process at the practice for generating the plans. Furthermore, he submitted that the Committee could also in due course find that this amounted to misconduct on the basis of Mr Bateman's opinion that it could amount to a significant departure from the GDC's Standards.

Mr Day's Oral Submissions

35. In his oral submissions, Mr Day responded to the points raised in Mr Patience's written submissions.
36. In respect of heads of charge 1 to 3, Mr Day submitted that there was no evidence that the reference to *'extraction'* in Patient B's records meant that the tooth was deliberately taken out. He submitted that it only meant that the tooth was taken out and did not go to the question of your state of mind at the time. In respect of Witness 1's evidence, he submitted that the GDC cannot rely on the ambiguity of the phraseology used in her evidence to support its case, particularly when the GDC did not explore this with the witness. In respect of Patient B's distress, he submitted that this cannot give an insight into your state of the mind at the time. In respect of your Rule 4 comments, he acknowledged that there was some ambiguity in your statement when you appear to state that you pushed the tooth. However, he submitted that given that the burden was

on the GDC to prove its case, this was insufficient evidence to show that your actions were intentional.

37. In respect of the heads of charge 4(a), 5 and 6, Mr Day referred to the GDC's neutral stance and submitted that this showed that the GDC recognised that Patient A's evidence was confusing, weak and tenuous.
38. In respect of the heads of charge 4(b), Mr Day acknowledged that it was open to the Committee to conclude that no treatment plan had been provided. However, he submitted that this could not amount to misconduct.

Mr Patience's Oral Submissions

39. In respect of heads of charge 1 to 3, Mr Patience submitted the reference to the word '*extraction*' in the records is an important and salient feature of the evidence that implies a deliberate removal. He submitted that Witness 1's evidence is only one strand of evidence, which the GDC relies upon. He submitted that her evidence was not ambiguous and therefore there was no need to clarify it. He submitted that Patient B's distress was indicative of the level of force used by you as the patient would not have been as distressed if the tooth came out accidentally. Furthermore, he submitted that your Rule 4 comments were also not ambiguous and a properly directed Committee could find that you had admitted that it was an intentional act. In conclusion, he submitted that each of these factors taken together could be sufficient for the Committee to conclude that there was a case to answer.
40. In respect of the heads of charge 4(a), 5 and 6, Mr Patience referred the Committee to his written submissions, as outlined above.
41. In respect of head of charge 4(b), he submitted that the evidence from Mr Bateman was that you had a duty to generate a treatment plan and that a failure to do so would amount to a significant departure from GDC Standards and therefore could amount to misconduct.

Committee's Decision

42. The Committee accepted the advice of the Legal Adviser and it applied the direction and test set out in the case of *R V Galbraith (1981) 1 WLR 1039*. The Committee also accepted the Legal Adviser's advice in respect of misconduct, and was directed to the relevant case law.
43. The Committee had regard to all the evidence thus far adduced. The Committee kept in mind throughout its decision making that the burden of proof rests entirely on the GDC and that it is not finding facts. The Committee was mindful that it must base its decision on the evidence presented by the GDC. The Committee had received your witness statement, dated 25 September 2025, and therefore it put this out of its mind when

making its decision. It took account of the written and oral submissions made by Mr Day, on your behalf, and those made by Mr Patience on behalf of the GDC.

44. The Committee did not simply dismiss any of the evidence presented by the GDC. It considered the totality of the evidence and considered each of the individual allegations in the context of the totality of that evidence. Heads of charges 1 to 6 all allege failure on your behalf. When deciding whether each or all of these charges could be proven, taking the evidence at its highest, the standard the Committee applied was that of a reasonably competent general dentist in general practice.
45. The Committee first considered heads of charge 1 to 3. It acknowledged that finding these allegations proved in due course could depend on whether your actions were deliberate or not. The Committee, therefore, considered whether it had been presented with sufficient evidence from the GDC, that when taken at its highest could prove that you had deliberately extracted Patient B's tooth.
46. The Committee first considered Witness1 's evidence, who was your Dental Nurse at the time and present at the appointment. However, in her witness statement, she stated that she could not recall much from this appointment even after being presented with the relevant dental records. She stated that you pulled Patient B's tooth out with your fingers and that the patient was crying. However, it was not clear whether she was suggesting that your actions were deliberate. Furthermore, in oral evidence she stated that her recollection of this appointment was limited. She was also very clear in her oral evidence that you are a very good dentist and that it was your usual practice to discuss treatment plans and treatment options with patients.
47. In respect of Patient B's dental records, the Committee noted that there is reference to an extraction. However, the Committee determined that this was not necessarily determinative as to whether it was intentional or not. The Committee noted that the records for this appointment were lacking in detail, for instance there was no reference to charting or the patient's oral hygiene, and therefore the omission of any further details about the extraction did not necessarily indicate that the extraction was deliberate.
48. The Committee next considered Mr Bateman's expert report and oral evidence. However, his opinion was based on an assumption that you had intentionally extracted the tooth rather than as an unintended consequence of mobility testing.
49. The Committee then considered your email to the GDC dated 17 December 2023 (Rule 4 comments). It noted that you were undertaking mobility testing, that the tooth came out accidentally and your actions were involuntary. It noted your comment that, *'I should have stopped and ask consent to finish but my finger pushed a few Newtons more and [the tooth] detached'*. However, the Committee did not consider that this amounted to an admission that your actions were intentional at the time, but rather it appeared that you were reflecting on events and stating how you should have acted differently.

50. Overall, the Committee, when looking at the totality of the evidence, determined that when taken at its highest, there was insufficient evidence adduced by the GDC on which a reasonable Committee, properly directed as to relevant law, could find heads of charge 1 to 3 proved to the civil standard.
51. The Committee next considered heads of charge 4(a) (i) to (iii) and whether you had communicated the treatment plan to Patient A at the appointments on 24 June 2021, 26 July 2021 and 23 August 2021.
52. The Committee first noted that Patient A's dental records clearly state that the treatment plan was discussed with Patient A at the appointment on 24 June 2021. This was also supported by Witness 1's evidence that it was your usual practice to discuss treatment options and plans with patients. The Committee concluded, therefore, that the evidence in the records could not support the GDC's case.
53. The Committee then went on to consider Patient A's evidence, both written and oral. The Committee noted that Patient A's initial complaint to the GDC, dated 16 January 2023, and his complaint to the practice were mainly focused on his appointment on 25 August 2021 when he believed his tooth was chipped and that he was wrongly charged £30 for this appointment. However, this did not assist the Committee when considering heads of charge 4(a) (i) to (iii) as the Committee noted that no charges have been raised by the GDC in relation to Patient A's appointment on 25 August 2021.
54. The Committee also considered Patient A's witness statement, but found this to be inconsistent regarding your communication with him. It noted that in his statement, Patient A stated that you never communicated with him but then contradicted this when stating, '*I think the Registrant gave me options of either a white filling or an amalgam filling and I opted for the white filling*'. This also appeared to contradict the reference in Patient A's statement that you never gave him any treatment options. Furthermore, Patient A stated that he did '*not recall that [you] ever examined in my mouth*'. However, it was clear to the Committee from Patient A's statement that when undertaking the fillings it was likely you would have undertaken some form of examination.
55. The Committee also noted from Patient A's oral evidence that although he did his best to assist the Committee, had co-operated with the GDC and answered all questions put to him, the passage of time had affected his memory of some events, which took place over four years ago. For example, it appeared that he had forgotten that he had a filling on 23 August 2021 in addition to a scale and polish.
56. The Committee considered Mr Bateman's expert report but noted that this was opinion evidence based on Patient A's witness statement and therefore would not assist the Committee in establishing the facts of the allegations.

57. For these reasons, when considering all of the evidence holistically, in context and at its highest, the Committee determined that the GDC had failed to provide sufficient evidence on which a properly directed Committee could find proved that you did not verbally communicate the treatment plan to Patient A at the appointment on 24 June 2021.
58. The Committee then considered whether there would have been a duty to discuss the treatment plan with Patient A on either 26 July 2021 or 23 August 2021. However, in light of its decision that head of charge 4(a)(i) could not be found proved, the Committee determined that the GDC had not provided sufficient evidence that there would have been a duty on you to discuss the treatment plan on either of these dates.
59. In respect of head of charge 5, the Committee noted from Patient A's witness statement that he attended the appointment on 23 August 2021 to have his teeth cleaned. There was no mention that he had a filling on this date. In oral evidence, he stated he was aware that he had a filling done but could not recall the appointment date. The Committee noted that there was no mention in his statement that he did not consent to this filling being undertaken. The Committee also noted that Mr Bateman appeared to base his opinion on Patient A's evidence.
60. Therefore, in light of the inconsistent evidence from Patient A, the Committee determined that the GDC had failed to provide sufficient evidence in which a properly directed Committee could find this head of charge proved.
61. The Committee next went on to consider heads of charge 6(a) and (b). In respect of 6(a) and Patient A's appointment on 24 June 2021, the Committee noted that the detailed records of this appointment show that you had discussed the treatment options and the treatment plan with Patient A. Furthermore, this was supported by Witness 1's evidence that this was your usual practice. The Committee determined therefore that there was insufficient evidence to show that you had not communicated adequately and appropriately with Patient A on this date.
62. In respect of head of charge 6(b) and the appointment on 23 August 2021, the Committee noted that Patient A was concerned that his tooth had been chipped during a scale and polish and that you should have discussed this with him. The Committee, therefore, considered whether there was any other evidence to support Patient A's assertion that his tooth had been chipped. The Committee noted that there is no evidence of this in the records for this appointment. The Committee also could find no evidence that you could have been aware at the time that his tooth had been chipped and therefore should have discussed this with Patient A. In his witness statement, Patient A stated that there appeared to be some confusion at the time as to whether you were aware of his chipped tooth. The Committee concluded therefore that the evidence from Patient A on this matter was unreliable.
63. The Committee also noted Mr Bateman's expert report, but this did not address the matter of Patient A's chipped tooth but rather was focused on the alleged failings that

you had not communicated the treatment plan to Patient A at this appointment. However, the Committee had already addressed this above at head of charge 4(a)(iii).

64. Overall, the Committee determined that, taken at its highest, the GDC's evidence was tenuous, lacking in reliability and insufficient for a properly directed Committee to be able to find heads of charge 6(a) and (b) proved.
65. Lastly, the Committee considered heads of charge 4(b) (i) to (iii). There was no evidence that Patient A had received a written treatment plan for the appointments on 24 June 2021, 26 July 2021 or 23 August 2021. The Committee also noted Mr Bateman's evidence that you had a duty to produce a written treatment plan and to ensure that this was given to Patient A. The Committee concluded, therefore, that there was sufficient evidence provided by the GDC so that a Committee could find this head of charge proved. The Committee rejected your application for No Case to Answer in respect of this charge.
66. The Committee then went on to consider whether such a failing could amount to misconduct if the Committee were to find it proved. The Committee reminded itself that not all misconduct is serious.
67. The Committee considered that a failure to provide a written treatment plan to a patient was serious as it breached the GDC's Standards. However, the Committee was also mindful that there was no other evidence that this constituted a pattern of behaviour. In contrast, the Committee noted Witness 1's evidence that providing a written treatment plan to patients was your usual practice. The Committee also noted that Patient A appeared to understand and be aware of the treatment that was provided and it seems that this was discussed with him at the first appointment on 24 June 2021. The Committee determined that if this allegation were to be found proved then this would appear to be an isolated incident in respect of one patient that occurred over four years ago.
68. The Committee, therefore, acceded to the No Case to Answer application in respect of all the heads of charge in this case, with the exception of head of charge 4(b). In respect of head of charge 4(b), the Committee determined that this failing could be considered by a properly directed Committee to be at the lower end of the scale of seriousness and as such could not amount to misconduct.
69. That concludes this hearing.