Dental Professionals Hearings Service

HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

23 February – 11 March 2026

Name:	**Andi, Margaret Data Ilanye**
Registration number:	**82258**
Case number:	**CAS-208716-L4Q0D2**

General Dental Council:	Mr Tom Stevens, counsel Instructed by Ervin Gjoleka of Capsticks solicitors
Registrant:	Present and represented by Mr Gavin Irwoin, counsel, instructed by Gareth Gibson of Weightmans solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Fitness to Practise Not Impaired. Case Concluded

Committee members:	Clive Powell (Lay) (Chair) Suki Sandhar (Lay) Caroline Ross (Dental Care Professional)
Legal adviser:	Kenneth Hamer
Committee Secretary:	Jamie Barge

Ms Andi

1. This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held in person at the GDC's Wimpole Street London offices from 23 February – 6 March 2026. Thee remaining week 9-13 March, to be held remotely via Microsoft Teams video link.

2. Mr Tom Stevens of counsel appears on behalf of the GDC. You are present and represented by Mr Gavin Irwin of counsel.

Preliminary matters – Application to joinder - 26 February 2026

3. Mr Stevens made an application on behalf of the GDC pursuant to Rule 25 of the 'General Dental Council (Fitness to Practise) Rules Order of Council 2006' (referred to as the Rules) to join additional allegations. He referred to the Rule 25 bundle sent to you and the Committee. He submitted that the GDC seeks to join further charges in respect of Patient 1 at head of charge 1, and records obtained for appointments and to include a revised time period and additional dates of alleged record keeping failures. Mr Stevens submitted these new allegations are similar to those already contained in respect of Patient 1. He submitted there would be no prejudice in joining these allegations.

4. Mr Stevens applied to join an allegation which would form head of charge 8d, that of

> 8.d "*You did not provide Patient 4 with the option of specialist referral following failed RCT"*;

5. Mr Stevens submitted that this is very similar to matters that are already subject to referral in head if charge 8. He submitted that again, there is no prejudice in joining this additional head of charge.

6. Mr Stevens also applied to add to head of charge 12 referenced to newly joined head of charge 8d. He submitted there was previously a clerical error in adding 8d to particulars to charge 12. He submitted that it should read "*8c and/or 8.f" was...".* Finally, Mr Stevens applied to add in head of charge 13 that it actually relates to head of charge 11 that captures the alleged conduct.

7. Mr Irwin made no objection to the GDC's application to join the above heads of charge.

8. The Committee heard and accepted the advice of the Legal Adviser.

9. Having regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that the requested joinder of allegations in respect of heads of charge 1, 8, 12 and 13, could be made without injustice. It noted no objection was made by Mr Irwin on your behalf.

Application to amend the charges pursuant to Rule 18

10. Mr Stevens, then made an application pursuant to Rule 18 of the Rules to make an amendment to the charges.

11. Mr Stevens applied to withdraw heads of charge 2a (including i, ii,iii and iv), and the adjoined consent charges 3, 4, 5, and 6. He submitted that following review of all the evidence before it, the GDC now consider that it fair and appropriate to withdraw these heads of charge. He submitted that the GDC had regard to your evidence and considered in effect that there is

insufficient evidence to support these heads of charge. Therefore, the GDC did not intend to rely on their evidence relating to those allegations.

12. Mr Stevens also applied in respect of head of charge 2.e, the GDC has reflected in your care in respect of Patient 2, the expert criticism is adequately captured by the particulars of head of charge 2.c Therefore he applied to withdraw head of charge 2.e as this is duplication.

13. Finally, Mr Stevens applied to amend head of charge 8, and in particular to amend the date period from "*20 May 2021 to 14 June 2021*". He submitted that all these amendments do not cause any injustice to you.

14. Mr Irwin on your behalf confirmed that you had no objection to the GDC's application to withdraw the charges and amendment as detailed.

15. The Committee heard and accepted the advice of the Legal Adviser.

16. Having regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that the required amendment could be made without injustice.

17. Therefore, the Committee accepted that allegations contained in heads of charge 2 and 8 are now amended.

The amended charge

18. The charge that you face at this hearing as set out below, reads as follows:

Th*at, being a registered dentist:*

A. You practised as a dentist at the dental practice referred to in Schedule 1 ("the Practice") and treated the patients listed below (and referred to in Schedule 1) from October 2019 to March 2022.

1. You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 12 October 2019 to 25 May 2021, in that you did note make and/or retain any record for appointments that took place on:

a. *12 October 2019;*
b. *26 October 2019;*
c. *20 December 2019;*
d. *1 February 2020;*
e. *27 February 2020;*
f. *15 September 2020;*
g. *7 October 2020;*
h. *9 March 2021;*
i. *30 March 2021;*
j. *25 May 2021.*

Patient 2

2. You failed to provide an adequate standard of care to Patient 2 from 17 June 2021 to 30 November 2021, in that:

a. *WITHDRAWN*

b. *On, or around, 27 October 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL5 without first removing all of the caries present in that tooth;*

c. *On, or around, 18 November 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL6 without first removing all of the caries present in that tooth;*

d. *You did not discuss with Patient 2 the option of specialist referral for further treatment of their LL6 after you root filled this tooth on 18 November 2021;*

e. *WITHDRAWN*

f. *On, or around, 30 November 2021 you provided a poor standard of treatment to Patient 2, in that, you filled their LL7 without first removing all of the caries present in that tooth.*

3. WITHDRAWN
4. WITHDRAWN
5. WITHDRAWN

6 WITHDRAWN

7 By reason of your conduct in charge 2.d. you did not obtain Patient 2's informed consent for not having further specialist treatment at their LL6.

Patient 4

8 You failed to provide an adequate standard of care to Patient 4 from 20 May 2021 to 14 June 2021 in that:
a You did not take a pre-operative radiograph, of sufficient diagnostic quality, in advance of undertaking RCT at their UR1;

b You did not adequately report on the post operative radiograph taken following RCT;

c You inaccurately informed patient 4 that you could not complete RCT on her UR1 because it was "fully sclerosed", or words to that effect;

d You did not provide Patient 4 with the option of specialist referral following failed RCT;

e You did not include the option of specialist referral within your letter to Patient 4's dentist, dated 14 June 2021;

f You inaccurately recorded in your letter to Patient 4's dentist, dated 14 June 2021, that their UR1 is "completely sclerosed."

9 By reason of your conduct in charge 8.a. you did not obtain Patient 4's informed consent for the RCT you provided at their UR1.

10 By reason of your conduct in charge 8.d. you did not obtain Patient 4's informed consent for not having further specialist treatment at their UR1.

11 *You failed to maintain an adequate standard of record keeping in respect of Patient 4, in that, you inaccurately recorded, in a record dated 20 May 2021, that you had "Adv patient that they will need to see a specialist when ready" following unsuccessful RCT at their UR1.*

12 *Your conduct in charge 8.c. and/or 8.f. was:*

a Misleading;

b Lacked integrity;

c Dishonest, in that you knew Patient UR1 was not fully / completely sclerosed and that the reason for your failed RCT treatment was because your access was in the wrong position.

13 *Your conduct in charge 11 was:*

a Misleading;
b Lacked integrity
c Dishonest, in that you knew you had not advised patient NT of the need to see a specialist.

Patient 5

14 *You failed to provide an adequate standard of care to Patient 5 from 20 May 2021 to 14 October 2021, in that:*

a. You did not take a pre-operative radiograph in advance of undertaking RCT at their UL6 on 14 October 2021.

15 *By reason of your conduct in charge 14.a. you did not obtain Patient 5's informed consent for the RCT you provided at their UL6.*

Background to the case and summary of allegations

19. The General Dental Council ("the Council") received a complaint in January 2022 from the Informant, who was a former associate in your practice. The Informant raised concerns about the treatment you provided to four patients.

20. In outline it is alleged that you were the treating dentist in respect of those patients, it is alleged that you failed to provide an adequate standard of care, in a number of areas including;

- Repeated examples of clinical notes not being recorded;
- Repeated examples of poor clinical note taking;
- Poor recording of justification and reporting on radiographs;
- Poor clinical standards relating to indirect restoration preparations and root canal treatment;
- Root filled patient s tooth without first removing all of the caries present in that tooth;
- Did not discuss with two patients the option of specialist referral for further treatment after you root filled the tooth;
- Did not diagnose and/or treat caries that remained in their LL6;
- Did not obtain Patient 2's informed consent for not having further specialist treatment at their LL6;
- Failure to take pre operative radiographs;
- A failure to treat a carious lesion on one patient because the patient was pregnant at the time. The tooth subsequently required RCT, suggesting that caries was extensive.
- Inaccurately informed a patient as well as inaccurately recorded in your letter to Patient 4's dentist, dated 14 June 2021, that their UR1 is "completely sclerosed."

- Failed to maintain an adequate standard of record keeping in respect of Patient 4, in that, you inaccurately recorded, in a record dated 20 May 2021, that you had "Adv patient that they will need to see a specialist when ready" following unsuccessful RCT at their UR1.

21. The GDC alleges that in respect of the last two bullet points, your conduct above is misleading, lacked integrity and was dishonest.

22. The GDC subsequently commissioned a report from a GDC expert, which was dated 12 April 2025 who concluded that the standard of care provided by you to Patients 1, 2, 4 and 5 was significantly below the level of professional practice reasonably expected.

Admissions

23. At the outset of the hearing, you made admission in respect to allegation 8.a.

24. Having carefully considered your admission as detailed by Mr Irwin, and the supporting evidence for the admitted head of charge, the Committee accepted your admission and found that charge proved.

Evidence

25. The Committee has been provided with documentary material in relation to the heads of charge that you face. This material includes:
    - The witness statements and documentary exhibits of the following witnesses:
        - Patient 4 dated 1 April 2025
        - Witness 2, Support Team Leader dated 16 February 2026;
        - Your witness statement dated 1 December 2025 and a supplementary dated 23 February 2026.
    - The expert reports of Edward Bateman, the GDC expert witness in this case, dated 12 April 2025 and a supplementary report undated,
    - Patient records of patients 1, 2, 4 and 5.
    - Defence expert report of Dr Brian Franks dated 20 February 2026;
    - Joint expert report dated 25 February 2026

26. The Committee heard oral evidence from Patient 4, the GDC expert witness, the defence expert witness and you.

27. In his expert report, Dr Bateman stated that some factors which might suggest that the failure was a serious one, or 'far below' are listed below (these should be seen neither as definitive nor as exhaustive):

    a. actual harm or unduly increased risk of harm to a patient, including a relatively small risk of very serious harm;

    b. the failure is a gross or significant departure from the standard expected;

    c. breach of the law/statutory requirement;

    d. foreseeability (reasonably foreseeable harm - deliberate/premediated conduct);

    e. the failure/failures are elemental and relate to basic skills;

    f. cumulatively the failings amount to a gross or a significant departure from the standard expected.

28. He stated that some factors which might suggest that the failure was a minor one, or 'below' are:

    a. No risk of harm to a patient;

    b. Failure to comply with an expected standard or requirement but that failure is not gross or significant;

    c. Inconsequential failure

29. The Committee did not understand Dr Franks to disagree with the examples given by Dr Bateman. The Committee has borne these matters in mind in determining your standard of care.

Committee's findings of fact

30. The Committee has taken into account all the evidence presented to it, both written and oral. The Committee has considered the submissions made by Mr Stevens on behalf of the GDC and those from Mr Irwin on your behalf. It has had regard to the GDC's *Guidance for the Practice Committees* effective January 2026.

31. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC and has considered the heads of charge against the civil standard of proof, namely, the balance of probabilities. It reminded itself of Collins J's observations in Lawrance v GMC 2015 EWHC 581(Admin) to the effect that in cases of dishonesty cogent evidence was required to reach the civil standard of proof.

32. The Committee has considered each head of charge separately.

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

	That being a registered dentist, *A. You practised as a dentist at the dental practice referred to in Schedule 1 below ("the Practice") and treated the patients listed below (and referred to in Schedule 1 below) from October 2019 to March 2022.*
	Patient 1
1	*You failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments from 12 October 2019 to 25 May 2021, in that you did not make and/or retain any record for appointments that took place on:*
1.a	*12 October 2019;* **Not proved.** You stated that you accept that as a fact there are no clinical records before the PCC in respect of Patient 1. However, you denied that you did not make any entries for this patient, or that those records were in any way deficient. You stated that it would be inconceivable that you would not have made records over a two-year period in relation to a single patient. Patient 1 was a patient you continued to see on a regular basis. You stated that the documentation provided in the bundle Tab B provide detailed entries you have made in respect of allegation regarding other patient consultations. In respect of the deletion records provided by the GDC, you stated that some were recorded at 3am, and there were dentists who had on occasion worked out of hours at the Practice. However, you maintain that some of the notes you

	recorded had disappeared from the system and the deletions identified were not made by you. You stated that it was your original belief that these were records that were taken and deleted by the complainant that have informed his complaint against you. However, upon reflection, you provided a supplementary statement that you now believe that the most likely person responsible for deleting patient records is who is another party who would sometimes take patient consultations at the Practice. You stated that he also had access to the Practice Dentally software. The Committee noted both parties agree that appointments took place on these dates. When looking at the retrospective records alongside, the Committee noted there are no records for the appointment on these dates. The Committee noted the issue of deletion, which was raised by you. Whilst the Committee has the written and oral evidence of Witness 2, nevertheless the Committee was not satisfied that Patient 1's clinical notes had been deleted by you. You maintain that you made those records. However, you also stated that when inputting noted there was no automatic save function on the computer system. It noted this patient attended from 12 October 2020 to 25 May 2021, where there are some entries in the computer system that shows Patient 1 attended over ten visits. The Committee noted there were inconsistencies with dates of records of patients in other heads of charge before you. The Committee having assessed all of the evidence before it, considered that it is highly improbable for you to have failed to make notes on ten occasions for one patient. This is the only patient in respect of this head of charge. The Committee is satisfied that is equally improbable you would not retain these records. The Committee accepts your written and oral evidence. It is satisfied on the balance of probabilities, that you had not failed to maintain an adequate standard of record keeping in respect of Patient 1's appointments identified, in that you did note make and/or retain any record for appointments. It therefore finds this head of charge not proved in its entirety 1a – 1.j.
1.b	*26 October 2019;* **Not proved for reasons given above.**
1.c	*20 December 2019;* **Not proved for reasons given above.**
1.d	*1 February 2020* **Not proved for reasons given above.**
1.e	*27 February 2020;* **Not proved for reasons given above.**
1.f	*5 September 2020;* **Not proved for reasons given above.**
1.g	*7 October 2020;*

	Not proved for reasons given above.
1.h	*9 March 2021;* **Not proved for reasons given above.**
1.i	*30 March 2021;* **Not proved for reasons given above.**
1.j	*25 May 2021;* **Not proved for reasons given above.**
	Patient 2
2	*You failed to provide an adequate standard of care to Patient 2 from 17 June 2021 to 30 November 2021, in that:*
2.a	*WITHDRAWN*
2.a.i	*WITHDRAWN*
2.a.ii	*WITHDRAWN*
2.a.iii	*WITHDRAWN*
2.a.iv.	*WITHDRAWN*
2.b	*On, or around, 27 October 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL5 without first removing all of the caries present in that tooth;* **Not proved.** Dr Franks stated in oral evidence that some soft caries can be left in a patient's tooth which would not cause damage to the tooth. He stated there is no evidence to confirm that by leaving hard caries in a tooth has directly on its own caused the tooth to be lost. Taking out more dentine in the tooth would lose the main structure of the tooth. He stated there are significant research papers which support minimally invasive dentistry to be adopted in this instance. In cross examination Dr Franks stated that he wasn't sure what type of caries were present in Patient 2's LL5. There can be circumstances where caries can be left in a patient's tooth. Dr Bateman disputed this and stated that in line with the relevant guidance from three respected bodies including the European Society of Endodontology, that all caries should be removed from a tooth before commencing root canal treatment (RCT). You stated that you removed all of the identified caries present in the LL5 on 27 October 2021. You stated that you reviewed the radiograph taken on 27 October 2021 and the experts reports. You maintain that the gap that is seen below the RC filling is not caries. That is a void. It was left as a normal course of treatment with was later sealed, as seen at 27 February 2022. It remains your position that at the time, you considered that you had removed all caries. The Committee considered whether caries was present. It took into account the radiographs and the subsequent care provided. The Committee had sigjht of radiographs taken on 27 October 2021, 8 November 2021, 30 November 2021 and 27 February 2022. Both experts agreed that caries remained. However, on 18 November 2021 you recorded "*will provide onlay*". Then on 30 November 2021, when the RCT had been completed, in the notes you have written "*caries cleared at the ADJ*". Following that, you recorded you had removed all remaining caries.

	The Committee noted both experts agree that it is more likely than not that radiolucency in the radiograph was caries in LL5 prior to root filling. The Committee accepts that you did not remove all of the caries prior to RCT. However, it noted soon after at the next appointment you had removed all of the remaining caries. It considered that you embarked on a series of actions to achieve the longevity of the tooth, and to ensure the integrity of the tooth and adopting a step-by-step approach. During this period of time, you took a clinical judgement in the best interests of this patient and eventually succeeded in removing all of the caries at LL5. It noted that you also kept contemporaneous and clinical notes identifying this planned course of action. The Committee recognises the position of the GDC and reference to the guidance. However, it noted this guidance is a statement which is not intended to substitute for a clinician's independent judgement in light of the circumstances and needs of a specific patient. The Committee also noted the facts of this particular case in that it was an ongoing course of treatment over a period of time. Therefore, the Committee is satisfied that you did not provide a poor standard of treatment and thereby you did not fail to provide an adequate standard of care in respect of Patient 2's LL5. It therefore finds this head of charge not proved.
2.c	*On, or around, 18 November 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL6 without first removing all of the caries present in that tooth;* **Proved.** You stated in your written statement "*I deny that I did not remove all of the caries present in the LL6 on 18 November 2021. I have reviewed the radiograph taken on 18 November 2021 and the experts criticism. The x-rays provided are 2 dimensional and therefore can show a side wall break that looks like caries when there none is present. The back wall of the tooth is in fact not present in the grey area. That was repaired with a GIC core and the wall was built with porcelain. …."* Dr Franks stated I the joint report " *The small 'dark' radiolucency at the distal aspect of the initial restoration at LL6 could be determined to be caries. However, it cannot definitively be disregarded as being a void caused by missing tooth tissue. Additionally, the 'grey' area appears to be showing an area of missing/displaced tooth tissue. Radiographs are a two-dimensional film of a three-dimensional situation. I am unable to ascertain from the radiograph the extent or 'consistency' of the caries left in situ and whether or not it was 'softer' active caries or 'hard' inactive (arrested) caries…In any event, the radiograph dated 27th February 2022 shows the definitive restoration in place and extending into the region of the previous radiolucency."* Dr Bateman stated in his report "*The post operative radiograph of LL5 from 27/10/2021 shows significant caries remaining in this tooth, and the x-ray taken at RCT completion of LL6 dated 18/11/2021 demonstrates significant caries remaining in LI5 and LL6 following RCT and this demonstrates a poor standard of RCT in both teeth, as it means it is not possible to get a coronal seal and leaves infected tooth substance within the tooth. All caries should be removed*

	from teeth when preparing an access cavity, before beginning root canal treatment." The Committee noted that both experts agreed in the joint report that caries remained in the tooth. It also noted that Dr Bateman written and oral evidence referred to three leading bodies guidance that clearly states that caries needed to be removed prior. It considered that this allegation comes down to clinical judgement. You stated that all the caries was removed and what was indicated in the radiograph was a fracture of the wall. Your contemporaneous clinical notes supported this. However, it noted during your oral evidence during cross examination, you changed your position, in that you stated you had removed a sufficient level of caries whilst taking into account the weakness of the tooth. The Committee having assessed the radiographs is satisfied on the balance of probabilities that although you had managed to seal the tooth, you had not removed all of the caries. Therefore, in line with current guidelines, this constitutes poor care that is below the standards expected, as by leaving caries in the patient's tooth, leaves the risk of further decay. The Committee finds this head of charge proved.
2.d	*You did not discuss with Patient 2 the option of specialist referral for further treatment of their LL6 after you root filled this tooth on 18 November 2021;* **Proved.** You stated in your written statement *"I deny that I was under an obligation to discuss referral to a specialist on 18 November 2021. As discussed above, I was acutely conscious that Patient 2 was a patient that I was seeing as an NHS patient and I was aware that she could not afford a private referral".* In oral evidence, you accepted as a matter of fact that you did not discuss the option of a specialist, however, you gave some background to the care provided to Patient 2. You stated that you would have discussed the option of a referral to an NHS hospital, however, there wasn't an option to do this as the hospital would not accept the referral as they did not have the funding. You stated that the patient had said to you that she had limited financial means and could not afford private treatment. You stated that was why you treated her free of charge. You consider that the failing to discuss a specialist referral was not a failure given the context of this patient. The joint report stated "*Both experts support the criticism in the HOC. As the MB canal was untreated, specialist referral should have been offered, and failure to offer meant informed consent was not obtained*". Dr Franks stated in oral evidence that he can understand why it wasn't done, given the circumstances of the patient, who had stated that she could not pay for private care. However, both experts agreed on the need to discuss the option of a specialist referral. The Committee noted on 18 November 2021 you had discussed the risks identified and provided some advice to what a sensitive conversation with the patient was. However, you did not offer the choice of treatment available. The Committee noted the GDC standards that consent should be gained by providing all of the options.

	The Committee considered that although you provided this patient free care, the patient must be presented with all options available to them, as agreed by both be experts. The Committee considered that you had a professional duty to inform of all options, regardless of the patient's financial circumstances. It finds that this falls below the standards expected and this head of charge is found proved.
2.e	**WITHDRAWN**
2.f	*On, or around, 30 November 2021 you provided a poor standard of treatment to Patient 2, in that, you filled their LL7 without first removing all of the caries present in that tooth.* **Not proved.** You stated that you deny that all of the necessary caries was not removed prior to the filling. You stated that no radiograph was taken on 30 November 2021 in order to prevent over exposing this patient to radiation. You also stated that current practice dictates that it is now best practice not to remove every bit of caries prior to providing a GIC core filling. You stated it is now best practice to remove all of the caries down to the hard dentine, which has the benefit of preserving tooth structure, a core value when practising minimally invasive dentistry. You stated it is your usual practice to then place the bulk of filler on to the base and seal the area around the root canal and build around this. This leaves a void, not caries, which is what is visible on the subsequent radiograph. However, you acknowledged that a little was left by the dentine, for the reasons already stated, and the remainder identified by the GDC expert is a void, rather than caries. Dr Bateman stated in oral evidence that there was caries left at the ADJ and therefore presents a risk of spreading infection. Dr Franks stated in the joint expert report "*The records of the Registrant dated 18th/30th November 2021 note that caries was removed to hard tertiary (sclerotic) dentine. Leaving some decay in a cavity before placing a filling can be a satisfactory and intentional clinical practice. The periapical radiograph dated 27th February 2022 shows a mesial radiolucency under the restoration at LL7 indicative of caries. I am unable to ascertain from the radiograph the extent of the restoration or the 'consistency' or extent of the caries left in situ. I am unaware if or when any further treatment has been required/provided at this tooth."* He stated in oral evidence the radiograph of 18 November 2021 of the LL7, and on left hand side of the tooth the mesial side of the tooth, shows a radiolucency and is indicative of caries and/or a defect. In addition, the radiograph of 27 February 2022, of the mesial side of the LL7, displays a dark radiolucency, however he stated some of what appeared before horizontally is not present. The Committee noted there is no dispute between both experts that caries was left in the tooth. Your clinical noted state that you had removed caries in the LL7. The noted of the subsequent dentist three months later, recorded that a clinical examination was caried out, radiographs taken. The Committee noted that the dentist at that time did not diagnose caries during the intra oral clinical

	examination, a recording following an assessment from a periapical radiograph which showed caries at LL7. Therefore, the Committee is satisfied on the balance of probabilities, that caries was not present on 30 November 2021. It considered that any caries that may have been present but would have developed in between your last examination and the examination undertaken by the subsequent treating dentist. It therefore finds this head of charge not proved.
3.	*WITHDRAWN*
4.	*WITHDRAWN*
5.	*WITHDRAWN*
6.	*WITHDRAWN*
7.	*By reason of your conduct in charge 2.d. you did not obtain Patient 2's informed consent for not having further specialist treatment at their LL6* **Proved.** You stated in oral evidence that as a consequence of the denials and description of treatment above, you do not accept that you did not obtain Patient 2's informed consent for any of the treatments provided. Both experts agreed that if the particulars in head of charge 2.d are proved, then there is clearly failing in you not being able to obtain informed consent. The Committee finds, that having found head of charge 2.d proved, it therefore follows that by failing to provide Patient 2 with option of a specialist referral, you could not have obtained the Patient 2's informed consent. The Committee is satisfied this is a minor breach in the circumstances in respect of GDC standards 3.1.2 and 3.1.3. However, the Committee finds this head of charge proved.
	Patient 4
8.	*You failed to provide an adequate standard of care to Patient 4 on 14 June 2021 in that*
8.a	*You did not take a pre-operative radiograph, of sufficient diagnostic quality, in advance of undertaking RCT at their UR1;* **Admitted as a fact – also found proved that you failed to provide an adequate standard of care.** The Committee considered that by not taking a pre-operative radiograph that was of sufficient diagnostic quality, prior to the RCT compromised the treatment to be provided. The Committee is satisfied that this failing falls far below the standards expected. It therefore finds this head of charge proved.
8.b	*You did not adequately report on the post operative radiograph taken following RCT;*

Proved.

Patient 4 in her oral evidence stated that she acknowledged this appointment occurred over 5 years ago and due to the lapse of time she couldn't recall all of the examinations that you performed on her. However, she remembered that she was in "desperate pain" and felt she did take in information that was provided by you to her. All she can remember is you providing treatment options available to her. Patient 4 also stated that she remembered that you had not referenced a referral to be made on 14 June 2021.

Patient 4 stated that after the failed procedure on 14 June 2021 she went to her local dentist who advised her to see an endodontic specialist dentist. Patient 4 acknowledged that she wasn't sure if she wanted an extraction.

Dr Bateman stated in his report "*The failure to adequately assess and report on the periapical radiographs has contributed to the failure of assessment of the tooth and communication of this in my opinion. When the pre-operative periapical radiograph exposed was not diagnostic, it should have been repeated. Without a diagnostic pre-operative periapical radiograph, the level of difficulty, and risk of failure could not have been assessed and communicated not the patient adequately preoperatively, making informed consent impossible. If the post-operative radiograph was properly assessed, it would be more likely than not, in my opinion that the Registrant would have seen that the endodontic access was in the wrong place, and that there was reasonable canal space visible above the access cavity*".

Dr Franks stated in the joint expert report "*The Registrant made a referral back to the patient's dentist in line with good practice. Although an option for referral to a specialist endodontist was omitted in the referral letter, it would be for the patient's dentist to provide options regarding further treatment. A referral to a specialist endodontist was the route taken and subsequently a satisfactory RCT was provided.* " He stated in oral evidence that if you do not have a post operate radiograph of sufficient diagnostic quality, it compromises the consent process.

You stated that Patient 4 was in a lot of pain and had been subject to a number of radiographs. You stated that if you felt you had made a mistake you would hold your hands up to that, however, it would have been beneficial to have a better quality of radiograph. However, when looking at the background of Patient 4's treatment, and what happened to her afterwards with her own dentist, it was impossible to expose her to that level of radiography. You stated that in this case, to take another radiograph was not justified.

You stated that having taken into account your clinical notes, alongside the letter you sent to her dentist, this would be an adequate report on the radiograph, given the context of this patient.

The Committee considered that both experts agree that you failed to report on the post operative radiograph, which you were responsible for Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) guidelines state that practitioners must report on radiographs taken.

The Committee is satisfied that this failing falls far below the standards expected.

It therefore finds this head of charge proved.

8.c	*You inaccurately informed patient 4 that you could not complete RCT on her UR1 because it was "fully sclerosed", or words to that effect;* **Not proved.** You stated in oral evidence that you do not dispute that you actually said that the tooth was fully sclerosed or words to that effect. You stated that you stopped treatment as you could not get full access to the main canal with your dental files as the canal was blocked. You stated at the time you felt that the tooth was fully sclerosed. However, you now accept, having assessed the joint expert report and associated radiograph, that it was incorrect to say that to Patient 4. Both experts state that it was inaccurate, as the radiographs clearly show that the tooth wasn't fully sclerosed and there was an issue of access. The Committee noted your written statement where you stated "*As matter of fact I accept that this was misleading as it turned out that the tooth was not fully sclerosed, however that was not my belief at the time as it was not accessible so I deny that there was any failing associated with recording such*". The Committee considers this is an accurate representation, as you considered at that time the tooth was fully sclerosed. The Committee is satisfied that at the material time your genuine belief was honestly held as in the clinic during an emergency appointment you could not access the patient's canal. The Committee therefore finds this head of charge not proved.
8.d	*You did not provide Patient 4 with the option of specialist referral following failed RCT;* **Not proved.** Patient 4 in her oral evidence stated that you did not provide her with the option of a specialist referral during this appointment. Patient 4 stated in oral evidence that option of the removal of her tooth was discussed by you and nothing else. Dr Bateman stated in his report "*There is no evidence of any perforation, and the Registrant, according to the noted recommended specialist referral to the patient. Ultimately this was carried out and the tooth successfully restored. I note that the patient, in a witness statement denies that they were advised of the possibility of specialist treatment. I cannot resolve this factual conflict, but if the patient was not advised of the possibility of specialist treatment, and was told the tooth needed to be extracted, then this would fall far below the standard expected, as ultimately, if this advice was followed, the patient would have lost a tooth that could likely have been kept for some time, with adequate root canal treatment*". *Dr Franks stated in the joint expert report "The Registrant made a referral back to the patient's dentist in line with good practice. Although it was noted in the referral letter that the canal was sclerosed and an option for referral to a specialist endodontist was omitted in the referral letter, it would be for the patient's dentist to provide options regarding further treatment. A referral to a*

	specialist endodontist was the route taken and subsequently a satisfactory RCT was provided." He further stated in oral evidence that from looking at the radiographs taken by a subsequent treating specialist, it wasn't fully sclerosed. He stated the letter Patient 4 went away with dated 14 June 2021 to the referring dentist was an acceptable course of action. Dr Franks stated at that at that point, it would be the responsibility of her own treating home dentist to take charge of the treatment going forward. You stated that you had recorded in your notes on 20 May 2021 that you had discussed the treatment options with Patient 4 and that this included the possibility of root canal treatment on referral to an endodontic specialist. You stated that you typed some of the notes prior and pasted this information into the patient record. You stated that you would not have recorded the possibility of a specialist referral had you not advised the patient of the same. You stated that the patient does not recall you advising that specialist treatment was an option, and that she can only recall you offered to do the procedure yourself. You stated that you are sorry if the patient did not understand your intentions clearly. You maintain that you did offer to attempt the treatment yourself as you consider you have experience providing root canal treatments and it was worth attempting in order to alleviate the patient's severe pain. However, you are adamant that you advised her of the option of seeing a specialist at this time. The Committee noted from the clinical notes recorded on 20 May 2021 and also for appointment on 14 June 2021, that you had discussed choices for UR1. The Committee noted the patient records for 20 May 2021 stating that a discussion was made regarding the option of removing the tooth and the option of re-root canal treatment to an endodontic specialist. It also took into account the letter drafted on 14 June 2021, a contemporaneous record which stated "*adv patient that they will need to see a specialist when ready*". The Committee noted you changed your position during oral evidence that you had discussions of a specialist referral. You stated that having seen Patient 4's face when she gave oral evidence last week, you now remember further details of what you alleged was discussed during that appointment. You deny you never gave the patient an option. The Committee considered Patient 4, who was in discomfort, and may have been mistaken in her version of events. She conceded in cross examination that she could not recall this appointment fully. The Committee accepts your evidence, that at that point you stopped the treatment that you were providing and referred back to Patient 4's dentist. This is in line with good practice, as stated by Dr Franks. The Committee therefore considered on the balance of probabilities that there was a discussion, albeit brief, of a specialist referral with Patient 4. The Committee therefore finds this head of charge not proved.
8.e	*You did not include the option of specialist referral within your letter to Patient 4's dentist, dated 14 June 2021;* **Not proved.**

	You accepted in your written statement that your letter of 14 June 2021 does not set out the option of a specialist referral to Patient 4's dentist. You stated that you had referred the patient back to their own dentist with this letter, you thought they would have been clear that this then required specialist input. You accept that your letter could and should have been clearer and apologise for that. Dr Bateman in his report stated "*Although there clearly was some sclerosis present, it is clear from the radiograph taken that the Registrant's access was in the wrong position, and that there was a reasonable canal space present further down the tooth, and specialist referral should have been given as an option also, so it could certainly be said that not all relevant information was provided by the Registrant on the letter. In my opinion, if the Registrant had looked clearly at the radiograph that it would have been more likely than not that she would have known that the access was in the wrong position, and that there was canal space evident. Risk of giving a letter to pt when missing out viable options, to reduce the risk of avoiding the risks such as missing out on issue of extraction that letter would then mean the next treating dentist would fail to pick it up later on*." The Committee considered that at that point you had managed to stabilise the tooth. You then referred the patient back to her dentist, who had access to all your dental records. The Committee is satisfied that it is a fact you did not include this in this letter. However, the letter was intended for the recipient dentist who would make their own clinical decision. It considered that the letter was simply to assist them in making their own professional opinion. The Committee accepts your evidence and is satisfied that this failure did not fall below the standards expected. It therefore finds this head of charge not proved.
8.f	*You inaccurately recorded in your letter to Patient 4's dentist, dated 14 June 2021, that their UR1 is "completely sclerosed."* **Not proved** You stated in your written statement that it was inaccurate to record that the UR1 was completely sclerosed. You said those were my findings on examination. You stated that you believed at the time that the tooth was fully sclerosed as using the equipment you had in the practice, you were not able to access the main root canal. You subsequently referred this for a further review by Patient 4's dentist. You dispute that your access point to the tooth was in the wrong position. You stated that you are very experienced in providing root canal treatments and know where to gain access. You finally stated that had you continued, you would have drilled through the side of the patient's tooth owing to the calcification present. Dr Bateman stated in his report "*… if the patient's own dentist had followed the Registrant's advice of this letter and not considered specialist referral as an option, the patient may have lost a tooth that could have potentially lasted for quite some more time. I note that the patient , in the witness statement, states*

	that they were not advised of the possibility of specialist referral or any other options". The Committee referred to its finding in 8c and considered that the content of the letter reflected your honest belief at the time of writing this and therefore does not amount to a failure to provide an adequate standard of care. It therefore finds this head of charge not proved.
9	*By reason of your conduct in charge 8.a. you did not obtain Patient 4's informed consent for the RCT you provided at their UR1.* **Proved.** You acknowledged in the cross-examination that you could not get 100% informed consent as a result of the deficiencies found in the associated radiograph. Both experts agree this goes to the issue of informed consent. Dr Franks admitted this in cross examination. The Committee is satisfied the preoperative radiograph was of suboptimal quality and had no real diagnostic content. Therefore, because of the poor quality of radiograph, you could not be able to properly assess and plan the treatment for Patient 4. The Committee is satisfied this presents a risk to the patient and is a falling far below the standards expected that of GDC standard 3. The Committee therefore finds this head of charge proved.
10.	*By reason of your conduct in charge 8.d. you did not obtain Patient 4's informed consent for not having further specialist treatment at their UR1.* **Not proved.** Having found head of charge 8.d not proved, it follows that this head of charge falls away.
11.	*You failed to maintain an adequate standard of record keeping in respect of Patient 4, in that, you inaccurately recorded, in a record dated 20 May 2021, that you had "Adv patient that they will need to see a specialist when ready" following unsuccessful RCT at their UR1.* **Not proved.** You stated in your written statement that this record entry should have been made against 14 June 2021. You are not certain as to why the practice record keeping system has entered that date against 20 May 2021 rather than 14 May 2021 when the treatment took place. In so far as the entry is made against the incorrect date, you accept that it is inaccurate. The Committee considered that this was a contemporaneous note. Having found head of charge 8.c and 8.d not proved, it is satisfied that this was not a failing below the standards expected and finds this head of charge not proved.
12.	*Your conduct in charge 8.c. and/or 8.f. was:*
12.a	*Misleading;*

	Proved as to 8.c. You stated in your written statement "*As matter of fact I accept that this was misleading as it turned out that the tooth was not fully sclerosed, however that was not my belief at the time as it was not accessible so I deny that there was any failing associated with recording such*". However, in oral evidence you stated that your conduct was not misleading. The Committee considered that this is proved as it had the potential to be misleading. However, as you honestly believed at the time the UR1 was fully sclerosed, the Committee consider your conduct in this respect to be a minor failing. **Not proved as to 8.f** The Committee considers that the letter was intended for the recipient dentist who would make their own decision. The Committee is satisfied your conduct in respect of the letter was not misleading.
12.b	*Lacked integrity;* **Not proved.** The Committee considered that you wrote something you considered to be true at that time. The Committee is satisfied that this does not demonstrate a lack of integrity or was dishonest. It therefore finds this head of charge not proved.
12.c	*Dishonest, in that you knew Patient UR1 was not fully / completely sclerosed and that the reason for your failed RCT treatment was because your access was in the wrong position.* **Not proved. For reasons given above.**
13.	*Your conduct in charge 11. was:*
13.a	*Misleading;* **This head of charge falls away having found head of charge 11 not proved.**
13.b.	*Lacked integrity;* **This head of charge falls away having found head of charge 11 not proved.**
13.c	*Dishonest, in that you knew you had not advised patient NT of the need to see a specialist.* **This head of charge falls away having found head of charge 11 not proved.**
	Patient 5

14.	*You failed to provide an adequate standard of care to Patient 5 from 20 May 2021 to 14 October 2021, in that:*
14.a	*You did not take a pre-operative radiograph in advance of undertaking RCT at their UL6 on 14 October 2021.* **Proved.** You stated that it was your usual practice to take a pre-operative radiograph, and the only situation you would not take one is when a pre operative radiograph has already been taken or if the patient was pregnant. You stated that Patient 5, a new patient, was pregnant when she attended the appointment in October 2021. You stated it was your usual practice to not undertake radiographs on pregnant patients as it risks exposing them to unnecessary radiation. You stated that you would have used her previous radiographs that the Practice had on file to measure the RCT against. You stated that a radiograph may have taken but could have been accidentally deleted. You stated that you cannot specifically remember this appointment due to the passage of time. You accepted that you navigated RCT without a pre operative radiograph. You stated you have performed 1000's of RCT with no issues whatsoever, and in this case, there must have must a valid reason why you did not take a radiograph. The Committee noted that Patient 5 stated to the Practice that she was pregnant in January 2021 and confirmed in July 2021 that she was due to give birth on 12 September 2021. The Committee is satisfied therefore it is highly unlikely she was still pregnant on 14 October 2021. Therefore, there is no justification for not taking a radiograph on that date. The Committee considered the clinical notes for Patient 5 on this date and there is no record or reference to a pre-operative radiograph been taken. In addition, there is no evidence of a contemporaneous being radiograph being taken. The Committee is therefore satisfied that you did not take a pre-operative radiograph in advance of undertaking RCT. It therefore considers that your conduct in this respect falls far below the standards expected and finds this head of charge proved.
15.	*By reason of your conduct in charge 14.a. you did not obtain Patient 5's informed consent for the RCT you provided at their UL6.* **Proved.** Both experts agreed this goes to the issue of informed consent. Dr Franks admitted this in cross examination. The Committee considered that by not taking a pre operative radiograph, you would not be able to properly assess and plan the treatment for Patient 5. The Committee considered that this presents a risk to the patient, and is a falling far below the standards expected, that of GDC standard 3. The Committee therefore finds this head of charge proved.

34. We move to stage two.

Stage Two of the hearing – 10-11 March 2026

35. The Committee's task at this stage of the hearing has been to determine whether the facts found proved amount to misconduct and, if so, whether your fitness to practise is currently impaired by reason of that misconduct. The Committee took into account that if it found current impairment, it would need to consider what sanction, if any, to impose on your registration.

36. In reaching its decisions, the Committee considered all the evidence presented to it, both at the fact-finding stage and at this second stage. The evidence received by the Committee at this stage was a remediation bundle provided on your behalf which included copies of your Personal Development Plan (PDP), audits, your self reflective statement, evidence of your Continuing Professional Development (CPD) and a number of testimonials.

37. The Committee took account of the submissions made by Mr Stevens, on behalf of the GDC, and Mr Irwin, on your behalf, in relation to misconduct, impairment and sanction. It also accepted the advice of the Legal Adviser in respect of these matters.

38. The Committee bore in mind that its decisions were for its independent judgement. There is no burden or standard of proof at this stage of the proceedings.

Summary of the facts found proved.

39. The facts found proved, relate to the standard of care that you provided to three patients, (2, 4 and 5) between October 2019 and March 2022 at the practice where you worked as a dentist ('the Practice').

40. It was the finding of the Committee, based on the evidence before it, there were a number of failings in the standard of care that you provided to these patients over the period in question. The Committee found proved, the following:

Patient 2

- On, or around, 18 November 2021 you provided a poor standard of treatment to Patient 2, in that you root filled their LL6 without first removing all of the caries present in that tooth;
- You did not discuss with Patient 2 the option of specialist referral for further treatment of their LL6 after you root filled this tooth on 18 November 2021;
- You did not obtain Patient 2's informed consent for not having further specialist treatment at their LL6.

Patient 4

- You did not take a pre-operative radiograph, of sufficient diagnostic quality, in advance of undertaking RCT at their UR1;
- You did not adequately report on the post-operative radiograph taken following RCT;
- You did not obtain Patient 4's informed consent for the RCT you provided at their UR1.
- Your conduct in that you inaccurately informed patient 4 that you could not complete RCT on her UR1 because it was "*fully sclerosed*", or words to that effect was misleading.

Patient 5

- You did not take a pre-operative radiograph in advance of undertaking RCT at their UL6 on 14 October 2021.
- You did not obtain Patient 5's informed consent for the RCT you provided at their UL6.

Summary of parties' submissions

41. It was Mr Stevens' submission that the facts found proved in this case relate to failings in fundamental aspects of dentistry. Mr Stevens made clear in his submissions that your clinical failings constitute misconduct, particularly in respect of your failure to obtain informed consent, flowing from radiographic failures in respect of patients 4 and 5. He submitted these failures compromised your ability to appropriate treatment plan in the absence of having a proper diagnostic view. He submitted the consequential failures to obtain informed consent is acknowledged in the GDC's *'Standards for the Dental Team'* (effective from September 2013). standard 3.1, that really lies at the heart of having trust within the dental profession. He submitted these are serious failings relating to basic and fundamental aspects of dentistry. Mr Stevens invited the Committee to consider on the areas of your practice that fell far below the standard expected and which constitutes misconduct.

42. In relation to current impairment, Mr Stevens submitted that in respect of public protection, the GDC is adopting a neutral position and acknowledges you haveundertaken an amount of remediation and that you had demonstrated insight into the concerns raised in this case. It considers the issue of public protection is a matter for the Committee's skilled judgment, on whether the discrete clinical errors, which occurred back in 2021, have been remedied. He submitted the Committee needs to consider whether there is a risk of repetition. He submitted that there has been no evidence or repeated failures since 2021. He submitted there is evidence of tailored remediation, particularly in respect of radiography. In addition, there are a number of positive testimonials from colleagues who testify to good practice.

43. In respect of public interest grounds, Mr Stevens submitted that given the seriousness of what has been found proved in this case, a finding of impairment would be required, in any event, to uphold public confidence in the dental profession and the regulatory process.

44. In addressing the Committee on the issue of sanction, Mr Stevens referred to the *'Guidance for the Practice Committees* (effective from 6 January 2026). Mr Stevens submitted that the issuing of a reprimand could potentially be appropriate in this case, if the Committee were to be satisfied that the factors for imposing a reprimand to satisfy the wider public interest.

45. Mr Irwin submitted that the tests haven't been met with regard to both misconduct and impairment. He submitted that in this context, the misconduct must be serious and has to be capable of being described of being deplorable. Mr Irwin submitted the failings found proved, 8.a, 8.b, 9, 14 and 15, were found to be far below, however, he submitted it does not cross the line as being deplorable. Mr Irwin stated given the context of the failings for these patients, this does not amount to misconduct.

46. Mr Irwin submitted that given the passage of time there has been no repetition. He submitted that in some respect these failures are isolated in nature and there is no evidence that your clinical failures were endemic. You have undertaken a volume of remediation, during which you have addressed all the concerns raised. Mr Irwin submitted you have reflected fully and you are now a better dentist. He submitted this demonstrates that there is no current impairment.

47. Mr Irwin invited the Committee to take into account your targeted CPD. He submitted that you have committed to undertaking relevant CPD covering all the criticisms made of you. You were not able to complete all your intended CPD for 2025, due to family issues. Mr Irwin drew the Committee's attention to audits provided in relation to your dental practice. He submitted that the audits had been a learning exercise for you, and he asked the Committee to note your commitment to this process as acknowledged in a number of positive testimonials from colleagues.

48. It was Mr Irwin's submission that the risk of any of the Committee's findings being repeated was extremely low, if not non-existent. He submitted that you have addressed all the identified issues, that you have made yourself knowledgeable in the field of dentistry, particularly in respect of radiographic practice. Mr Irwin submitted that there is no ongoing risk to patient safety in this case.

49. Mr Irwin submitted that a fair-minded member of the public would not be shocked or concerned if there was no finding of impairment in all the circumstances.

50. In relation to sanction, Mr Irwin submitted that, should the Committee find current impairment, then a reprimand would be an appropriate disposal.

Decision on misconduct

51. The Committee considered whether the facts found proved against you amount to misconduct. It took into account that a finding of misconduct in the regulatory context requires a serious falling short of the professional standards expected of a registered dental professional.

52. In its deliberations the Committee has had regard to the following paragraph of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. This paragraph states that as a dentist:

> *3.1 You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.*
>
> *3.1.1 You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members have already seen them. Do not assume that someone else has obtained the patient's consent.*
>
> *3.1.2 You should document the discussions you have with patients in the process of gaining consent. Although a signature on a form is important in verifying that a patient has given consent, it is the discussions that take place with the patient that determine whether the consent is valid.*
>
> *3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:*
>
> *• options for treatment, the risks and the potential benefits;*

- *why you think a particular treatment is necessary and appropriate for them;*
- *the consequences, risks and benefits of the treatment you propose;*
- *the likely prognosis;*
- *your recommended option;*
- *the cost of the proposed treatment;*
- *what might happen if the proposed treatment is not carried out; and*
- *whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.*

53. In deciding on the issue of misconduct, the Committee considered its findings separately and took into account the joint expert opinion in relation to the individual matters. The Committee has found that your conduct in relation to heads of charge 8(a), 8(b), 9, 14 and 15 of the Charge fell far below the standard of care expected of a reasonably competent dentist. The Committee considered whether in the light of their findings of fact under these paragraphs, individually or cumulatively, your conduct amounts to serious misconduct.

54. The Committee noted that Dr Bateman stated that heads of charge 8.a, 8.b, 9, 14 and 15 represented a standard of practice that fell far below what was expected. He further explained that failing to obtain informed consent from patients 2, 4 and 5 could have led to a risk of harm.

55. The Committee noted the issues have narrowed to failures in radiographic practice and informed consent in respect of two patients. However, it considers these failings relate to basic fundamental aspects of dentistry. You failed to obtain appropriate information in order to provide individualised treatment in respect of two patients. The Committee considered whether these failures would amount to being serious and deplorable by other practitioners.

56. The Committee took into account the context of the identified failings which fell far below the expected standard. In respect of Patient 4 you treated this patient at an emergency appointment and attempted RCT to alleviate Patient 4's extreme pain. When you realised you could not complete the RCT you immediately stopped and referred the patient back to her general dentist for further treatment planning. In respect of the radiographic failure, you failed to obtain a radiograph of sufficient diagnostic quality which restricted your ability to gain informed consent, this was isolated in nature, given you have 15.000 patients registered to you and a long unblemished career. In respect of Patient 5 the radiographic failings are similar in that you failed to obtain a pre -operative radiograph prior to commencing RCT and therefore failed to obtain informed consent, there was some confusion from you as to whether Patient 5 was pregnant or breast feeding and you expressed you were limiting her radiographic exposure.

57. However, the Committee is satisfied that the identified clinical failures were a departure from the standards identified above. It considers that although you endeavoured to act in the best interests of two patients, you failed on more than one occasion to obtain informed consent. The Committee considers your clinical failings relate to fundamental dentistry which presented a real risk of harm to these patients. The Committee is satisfied that the matters in heads of charge 8.a, 8.b, 9, 14 and 15 do fall far below the standards and amount to serious misconduct. They represent a serious departure from the basic standards of dentistry and an associated risk to patient safety.

58. The Committee then went onto consider the remaining heads of charge. It found that whilst paragraphs 2(c), 2(d), and 7 were proved, it is satisfied your conduct did not fall far below the standard expected, and that in relation to paragraph 12(a) the conduct was a minor failing. The Committee is satisfied that these failings do not amount to serious misconduct.

59. Accordingly, the Committee was satisfied that all of the facts found proved in this case, save for its finding at heads of charge 2(c), 2(d), 7 and 12.(a) amount to misconduct.

Decision on current impairment

60. The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. It had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

61. The Committee took into account that its findings in this case relate to clinical failings. It was satisfied that the identified deficiencies are matters that are capable of being remedied. In considering whether they have been remedied, the Committee had regard to the evidence of the steps that you have taken to address the concerns arising from the care you provided to patients 4 and 5.

62. It was the view of the Committee that you have demonstrated genuine remorse for your failings. It noted from your oral evidence given at the fact-finding stage of this hearing that you apologised for what happened and fully accepted that you made mistakes and you now recognise the seriousness of your clinical errors. The Committee took into account that you have acknowledged that this has been a learning curve for you. It was the impression of the Committee, having heard from you and assessed your reflective statement, that you are a practitioner that cares about what you do. It found this to be reflected in the remediation that you have undertaken. It was clear to the Committee from your learning and the written reflection you have provided, that you have thought deeply about the standard of care that you provided to the patients in this case and that your attendance at the hearing has been a salutary experience.

63. The Committee has received tailored remediation and found your remediation to be of good quality. Although you have failed to provide an appropriate level of CPD for 2025, you have provided valid reasons why you were not able to do this. In the circumstances, the Committee concluded that any small limitations in your remediation in these regards did not detract significantly from the quality of the evidence placed before it. You have undertaken targeted CPD, covering all the concerns raised in this case. The Committee noted that you have completed a number of courses as well as learning in relation to clinical record keeping and radiography. The Committee also had before it audits in relation to your work over a period of time, which demonstrate that there has been improvement in the identified deficient areas of your practice.

64. The Committee was satisfied, having considered the totality of the evidence of your remediation, that you have demonstrated a good level of insight into your failings concerning the patients. The Committee was satisfied that you are sufficiently aware of what went wrong, that you have accepted full responsibility for your shortcomings, and that you have undertaken extensive and focused steps to address the matters that brought you before your regulatory body.

65. It was the judgement of the Committee, on the basis of all the evidence provided, that you have remedied your failings, and the risk of repetition is low. Accordingly, the Committee determined that a finding of impairment is not necessary in this case for the protection of the public.

66. The Committee went on to consider the wider public interest. In doing so, it had regard to the seriousness of your misconduct, including in relation to radiographic practice and informed consent. The Committee considered whether an informed, fair-minded member of the public would be concerned if a finding of impairment were not made in the context of what were serious failings.

67. In reaching its decision, the Committee balanced the seriousness of your misconduct with your apology and genuine remorse for your misconduct, the quality of your remediation and the insight you have shown during the public hearing lasting many days. The Committee also took into account your engagement, the passage of time together with the volume of positive testimonial evidence tendered on your behalf. In addition, the Committee considered the impact that these fitness to practise proceedings have had on you, and that a finding of misconduct in itself is a serious outcome for any registered professional. It was the decision of the Committee, having considered these factors, that public confidence in the dental profession and the maintenance of professional standards would not be undermined if a finding of impairment were not made. The Committee was therefore satisfied that such a finding was not required in the wider public interest.

68. Accordingly, the Committee determined that your fitness to practise is not currently impaired by reason of your misconduct.

69. The Committee determined that given your level of remediation and level of engagement, the misconduct identified does not need to be marked by the imposition of a sanction.

70. That concludes this determination.