PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

8 - 18 June 2026

Name:	VATISH, Suraj
Registration number:	259241
Case number:	CAS-203215

General Dental Council:	Daniel Mansell, Counsel Instructed by Natalie Ayling, Capsticks
Registrant:	Present Represented by Andrew Colman, Counsel Instructed by Sunil Abeyewickreme, Gunnercooke LLP

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspended with immediate suspension (with a review)
Duration:	4 months
Immediate order:	Immediate suspension order

Committee members:	Jill Crawford (Chair, Lay Member) Janhvi Amin (Dentist Member) Lisa Shaw (Dental Care Professional Member)
Legal adviser:	Paul Moulder
Committee Secretary:	Jenny Hazell

The charge against Suraj Vatish was as follows: That, being registered as a Dentist:

1. You failed to obtain informed consent for the treatment for tongue tie provided to Patient A (identified in Schedule A) on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all:

(a) the risks of the treatment;

(b) the treatment options.

2. You failed to obtain informed consent for the treatment for lip tie provided to Patient A on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all:

(a) the risks of the treatment;

(b) the treatment options;

(c) the limited evidence base for the treatment;

(d) the cost of treatment.

3. You failed to obtain informed consent for the off-label use of a topical anaesthetic paste in Patient A's mouth on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all, the risks of using the paste intra-orally.

4. You failed to obtain informed consent for the treatment provided to Patient A on 13 February 2023, in that you did not discuss with Patient A's Parents, adequately or at all:

(a) the risks of the treatment;

(b) the benefits of the treatment;

(c) the treatment options.

5. You failed to provide an adequate standard of care to Patient A on 13 February 2023, in that you reopened the wounds when this was unsafe given the passage of time since the initial procedures.

6. You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments on 27 January 2023 and 13 February 2023, in that you did not record, adequately, or at all:

(a) details of discussions around consent;

(b) justification for the treatment provided;

(c) discussion of risks;

(d) details regarding laser settings;

(e) post-operative explanations.

(f) justification for the off-label use of a topical anaesthetic paste.

7. You failed to respond appropriately to complaints from Patient A's Parents, in that you:

(a) did not ensure a written response was sent in a timely manner;

(b) reacted defensively to the complaint and/or did not offer an apology;

(c) made the provision of a refund conditional on Patient A's father signing an 'Agreement form' which stated:

(i) "I agree and confirm my decision to agree to this release has not been influenced in any way by any representations of Dr Suraj Vatish";

(ii) "I agree that I will keep the terms of this settlement and the facts pertaining to this matter confidential. I will not disclose any details to any external parties."

(iii) "I agree to remove any reviews left on [Practice A's] dental pages."

8. In an internal email, dated 21 February 2023, you wrote:

(a) that Patient A's mother "has some of her own issues and health problems";

(b) that Patient A's Parents were "playing the system";

(c) that Patient A's Parents "mislead us".

9. Your conduct above:

(a) in relation to Heads of Charge 7 and/or 8, failed to treat Patient A and their Parents with dignity and respect;

(b) in relation to charges 7 and/or 8, was unprofessional;

(c) in relation to charge 7(c)(i) and/or 7(c)(iii), was misleading;

(d) in relation to charge 7(c)(i), was dishonest, in that you knew this was inaccurate;

(e) in relation to 7(c)(iii), was dishonest, in that you knew this would create an inaccurate impression of patient satisfaction.

And that by reason of the matters set out above, your fitness to practise as a Dentist is impaired by reason of your misconduct.

1 This hearing before the Professional Conduct Committee ('the Committee') was convened for the purposes of an inquiry into a charge against you.

2 You are present this hearing and are represented Mr Colman, Counsel. Mr Mansell, Counsel, appears on behalf of the General Dental Council (GDC).

3 At the outset Mr Mansell made an application under Rule 25(2) of the GDC (Fitness to Practise) Rules 2006 ('the Rules') to join a new allegation (numbered 5) to the Notice of Hearing as follows:

> *You failed to provide an adequate standard of care to patient A on 13 February 2023 in that you reopened the wounds when this was unsafe given the passage of time since the initial procedures.*

4 Mr Mansell submitted that the new allegation arises from the expert opinion of Dr Levinkind (GDC's expert) as set out in his report dated 26 February 2026. Dr Levinkind confirmed that criticism in the joint report with Dr Baxter dated 8 June 2026. The GDC's position is that this allegation relates to the same patient (Patient A) regarding the same course of treatment and is based on the same evidential basis upon which the GDC relies in support of the other allegations. It was Mr Mansell's submission that they therefore fulfil the requirements of Rule 25.

5 Mr Mansell indicated that the GDC was no longer intending to invite the Committee to consider a second new allegation to the Notice of Hearing as part of the application for joinder. This was because the matter set out in that proposed new allegation were reflected in other allegations. That allegation was as follows:

> *In providing the treatment to Patient A on 27 January 2023 and 13 February 2023, you were working beyond the limits of your competence.*

6 Mr Colman, on your behalf, raised no objection to the GDC's application. He confirmed that the GDC had notified you of the proposed joinder application well in advance of the 28 day notice period set out in Rule 25 (3)(b).

7 The Committee heard the submissions of both Counsel in respect of each application. It accepted the advice of the Legal Adviser on this matter.

8 The Committee was satisfied that the allegation which forms the subject of the GDC's Rule 25 application relates to the same patient (Patient A) and is of a similar kind to that set out in the Notice of Hearing. It was satisfied that the application complies with Rule 25(2). Accordingly, the Committee acceded to Mr Mansell's Rule 25(2) application to join the additional allegation (numbered 5) set out above. In respect of the second allegation, the Committee noted that this did not form part of the GDC's application, but in any event, it was satisfied that the remaining substance of Dr Levinkind's criticism was covered by other charges.

Admissions

9 At the outset, Mr Colman, on your behalf admitted the matters set out in charge 8. This position was confirmed in your written responses to the allegations dated 25 May 2026. The Committee determined and announced that charge 8 was proven on the basis of your admissions in accordance with Rule 17(4).

Summary of the case

10 At the relevant times you were practising at Practice A (the Practice). This case concerns your treatment of Patient A for lip tie and tongue tie treatment in January 2023. Patient A attended the Practice on 27 January 2023, accompanied by her parents, Parent 1 and Parent 2, following a referral by their lactation consultant as Patient A had feeding issues. The lactation consultant recommended that Patient A see you so that you could use a laser to operate on the tongue-tied. Prior to the family's attendance, the family was sent a video to watch which outlined the tongue-tied procedure, the "Frenectomy Information Pack" on 17 January 2023 and an on-line consent form which Patient A's mother (Parent 2) signed on 19 January 2023 prior to their visit.

Initial appointment 27 January 2023

11 At the initial appointment you conducted an oral examination and indicated that there was a tongue-tied and an upper lip that needed to be released. The parents were asked to leave the room while the procedural was carried out. Patient A remained in the dental chair and was prepared for the procedure. You applied EMLA 5% topical Lidocaine intra-orally to Patient A. You then performed a laser tongue-tie release and upper lip tie release on Patient A at the same visit.

Post operative review appointment 13 February 2023

12 A review appointment took place on 13 February 2023 (17 days after the surgery). Parent 1 and Parent 2 were both present. At that appointment you examined Patient A and noticed that the wound sites were tight. You stretched the wounds to improve mobility which caused some bleeding to Patient A.

13 You telephoned Patient A's parents on the evening of 13 February 2023 to find out how the mother and Patient A were doing. At the time when you made the call you were unaware that Parent 2 had sent a complaint to the Practice that same evening.

14 You made a further telephone call the following day (14 February 2023) to find out the mother and Patient A were doing.

Complaint and internal communications

15 Parent 2 sent a formal complaint to the Practice by email dated 13 February 2023 at 20.58 which related to the follow-up appointment they had with you. Parent 2 stated as follows: "We are not at all happy that both our daughter's tongue and lip wounds were re-opened, without discussion nor any sort of permission."

16 You were notified of Parent 2's complaint by the Operations Director on 16 February 2023. Thereafter, the followed an exchange of emails between you and Patient A's parents in respect of their complaint. You offered a full refund, asking the parents to remove their review from the Practice and to sign an agreement form. Initially, Parent 1 agreed to modify the review and accept an apology. However, Parent 1 declined to remove the entire review and sign the agreement.

17 In response to the parents' complaint to the Practice, the Practice Manager accidentally copied them in on an internal email dated 21 February 2023 between you and the Practice Manager, and the operations director. In that email you described the mother as someone who "*has some of her own issues and health problems*. You described Patient A's parents as "*playing the system*" and that they "*mislead us"* [the Practice].

18 In due course the parents of Patient A chose to escalate the matter with a firm of solicitors and subsequently to the GDC.

Evidence

19 The Committee received the following evidence provided by the GDC:

- Patient A's dental records;
- Parent 1's witness statement, signed and dated 18 April 2025, with associated exhibits;
- Parent 2's witness statement, signed and dated 16 April 2025, with associated exhibits.

20 The Committee also received oral evidence from Parent 1 and Parent 2 in which they confirmed the contents of their signed witness statements.

21 The Committee received the following evidence on your behalf:

- A copy of your witness statement, signed and dated 15 September 2025, with associated exhibits;
- Witness statement dated 12 September 2025 from the trainee dental nurse (the Dental Nurse) who assisted you at both of the appointments;
- Your responses to the final charge and rule 25 allegation;
- A photograph of the layout of the surgery;
- Email (redacted) dated 16 February 2023 from the Operations Director to you, attaching a copy of Parent 2's formal complaint against you regarding your treatment of Patient A.

22 In addition, the Committee had regard to your oral evidence. In your evidence you set out your position in respect of each of the allegations. In short you deny the allegations and maintain that you always ensure that all parents receive adequate information regarding diagnosis, treatment options, including the choice of no treatment, consent, risks, benefits, costs and aftercare requirements. You further set out that for every procedure, you stress the necessity of aftercare, including wound-stretching exercises and the importance of attending a follow-up review seven days after surgery.

23 The Committee also received oral evidence from the Dental Nurse. She accepted that she did not have a specific memory of things happening at the two appointments in question but was basing her evidence on what normally happened.

24 The Committee also received expert evidence from Dr Levinkind (instructed by the GDC), a paediatric dentist with over 45 years of clinical, specialist paediatric experience. Dr Levinkind produced a report dated 26 February 2026 in which he set out his criticisms of your practise in a number of respects. These were assessed against the GDC's Standards of the Dental Team, including standards 3.1, 3.2, 3.3 and 4.1 Dr Levinkind also produced a supplemental report dated 16 February 2026, having reviewed additional documentation relating to your undergraduate education, mentorship experience, implant diploma and attendance at courses. Dr Levinkind gave oral evidence before the Committee in which he broadly confirmed the contents of his report.

25 The Committee noted that Mr Colman raised with Dr Levinkind that he was one of two practitioners at this level providing laser frenectomy to babies and children privately in London, the other being you. As such Mr Colman made the point that Dr Levinkind and you are commercial competitors. The Committee was also informed that Dr Levinkind and you had met during the course of your work at professional events. The Committee considered that Dr Levinkind had considerable expertise in this area. At times, the Committee considered that Dr Levinkind's evidence was informed

by his personal practice rather than general clinical standards. It considered that on some issues it was difficult to understand his final position on the level of departure from the relevant standards.

26 The Committee received expert evidence from Dr Baxter (instructed on your behalf), a paediatric dentist with a special interest in oral restrictions with 12 years' clinical experience in the USA. He confirmed that he has never practised in the UK. Dr Baxter produced a report dated 30 April 2026. Dr Baxter gave oral evidence in which he confirmed the contents of his report. The Committee noted from Dr Baxter's report that he had created the Tongue-Tied Academy course which you had attended. It has borne in mind that you trained at one of Dr Baxter's courses.

27 The Committee considered that Dr Baxter had considerable expertise in this area, albeit outside the UK. However, it considered that at times, Dr Baxter gave evidence based on his personal practice and a conviction about what attendees from his course would do. It was difficult at times to ascertain Dr Baxter's views on what constituted a reasonable standard of care generally rather than his view as to what took place.

28 The experts produced a joint report dated 8 June 2026 in which they set out their respective charges. Both agreed that the applicable standard against which your conduct falls to be assessed is the standard expected of a reasonably competent UK GDC registrant at the time of the relevant events. They also accepted post-operative reattachment following frenectomy is a recognised and common complication of the procedure. In addition, the experts accepted that there was a clinical evidence base supporting the combined treatment of tongue-tied and lip-tie. Furthermore, both experts accepted that EMLA (2.5%lidocaine/2.5% prilocaine) was in widespread use within the tongue-tie clinical community in the UK and internationally at the time of the procedure in January 2023, including in the practice of experienced practitioners.

29 At the close of the GDC's case, Mr Mansell made an application under Rule 18 to amend the charge in the form of the removal of Charge 6(e) which concerns a failure to maintain an adequate standard of record keeping in respect of post-operative explanations. This was in light of Dr Levinkind's oral evidence in which he conceded that the record keeping in respect of post-operative explanations was adequate. Mr Colman indicated that he did not oppose the application.

30 The Committee had regard to the submissions of both Counsel. It accepted the advice of the Legal Adviser. It has borne in mind the need to be fair to all parties, as well as the public interest. The Committee was satisfied that it was fair to allow the GDC's application given that the evidence of Dr Levinkind no longer supports Charge 6(e). Accordingly, it acceded to Mr Mansell's application and charge 6(e) is therefore withdrawn from proceedings.

Findings of Fact – 16 June 2026

31 The Committee considered all the evidence presented to it, both documentary and oral. It took account of the submissions on the alleged facts made by Mr Mansell and by Mr Colman parties. The Committee accepted the advice of the Legal Adviser.

32 The Committee considered the factual allegations separately, bearing in mind that the burden of proof rests with the GDC and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities. In respect of the allegation that your conduct was dishonest, the Committee applied the test set out in *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] UKSC 67. The test is that the Committee must decide subjectively the actual state of an individual's knowledge or belief as to the facts, and must then apply the objective standards of ordinary and decent people to determine whether the individual's conduct was dishonest by those standards.

33 The Committee made the following findings:

1	*You failed to obtain informed consent for the treatment for tongue tie provided to Patient A (identified in Schedule A) on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all:*
1a	*the risks of the treatment* **Found not proved** The Committee has had regard to Patient A's dental records for 27 January 2023. The notes of the discussion record: bleeding, swelling, damage to adjacent areas of structure. The records go on to state: "*Advised frenectomy informed Nil* *1) Tongue-tie / lip-tie may re-attach/ may need another procedure* *2) Bleeding, swelling, infection* *3) Salivary glands are in close proximity and might be affected* *4) Feeding may not improve or may get worse before getting better* *5) Speech or feeding may still be affected later in life* The Committee has had regard to the evidence of Parent 2 (the mother of Patient A) and Parent 1 (the father of Patient A). Parent 2's evidence was that at the appointment you conducted an oral examination on Patient A and indicated that there was a clear tongue-tie but also a lip-tie which should be operated on. Her evidence was that there was no discussion of the cons of a tongue-tie procedure during the appointment. It was put to Parent 2 that in addition to the information already given there was a further discussion at the appointment of 27 January 2023. Her evidence was to the effect that "There was no discussion of the cons of a tongue-tie procedure during the appointment", Save for, "All the reasons why it was imperative my child had a tongue-tie procedure." Parent 1 set out in his witness statement as follows: "The Registrant indicated that not doing a tongue-tie release could lead to difficulties around speech, facial development and mouth breathing. There was no detailed discussion about the risks of carrying out the procedure during the appointment. There was some discussion about the risks of reattachment, sticking to the post-operation routine and meeting the cranial osteopath. There was no detailed discussion about the risks of carrying out the procedure during the appointment. Alternative treatments were not discussed but the Registrant indicated a holistic approach should be taken which would help with overall recovery." Your evidence, as set out in your statement, is that prior to attendance on 17 January 2023, the family had been sent the the "Frenectomy Pack". This detailed the nature of tongue-tie and lip-tie release procedures, associated risks, alternatives, and costs. The consent form was signed on 19 January 2023, and records confirm the materials had been read, as can be seen on the signable audit. You explained that prior to receiving Patient A and her parents, you checked that the Frenectomy Pack had been signed and that the medical history had been completed. You set out that in accordance with your standard protocol, you would explain all key issues before examining the child. You explained that you would discuss symptoms disclosed on the referral and consent documents, which included colic, licking during feeding, mouth breathing, gagging and

falling asleep during feeding. Your evidence is that you explained to Patient A's parents that there were two main options for managing her condition – either no treatment, or release of the tethered oral tissues. You clarified with the parents that not all children with tongue tie require intervention as some compensate. However, in other cases tongue ties can contribute to difficulties with speech, feeding, airway function or dental development.

You went on to explain that you described the available release methods: scissors (which you do not offer in your practice) and laser (your standard practice). Your evidence is that the risks of any release were explained in detail, consistent with the written consent, namely: bleeding, infection, pain, scar formation, risk of re-attachment, need for further procedures, nerve damage. Your evidence was that you explained that breastfeeding improvement is not guaranteed following the procedure, because feeding outcomes depend on many factors beyond the tongue tie itself such as maternal milk supply and positioning.

In your oral evidence you explained that it was and is your standard practice to discuss the rationale for treatment, expected benefits, risks, aftercare and alternatives for each parent. You maintain that all appropriate discussions took place with Parent A's parents.

The dental nurse accepted that she did not have a specific memory of things happening at appointments but was basing her evidence on what normally happens. Her evidence was that it was your routine practise to discuss with the parents the risks and benefits options. She described how you would follow this routine religiously. There was nothing unusual in this appointment that stuck out in her mind.

Dr Levinkind's evidence was that for informed consent to be adequate there must be a structured discussion, an understanding of the risks and alternatives, a voluntary decision and the discussion should be documented. He opined that there was no meaningful record of consent exists beyond the online form accessed before the appointment and signed by the parents four days before the initial consultation. He set out that under UK GDC standards and the Montgomery principle, a clinician is required to ensure that patients -and in this case parents – are given the information a reasonable person in their position would want to know before consenting. Dr Levinkind maintained this criticism of a lack of consent in the joint report and in his oral evidence.

In Dr Levinkind's oral evidence, he re-confirmed the position set out in his joint report – namely that the records do not demonstrate adequate consent. .

Dr Baxter's position is that this head of charge is not supported by the evidence. He opined that written consent and verbal consent was obtained prior to the procedure and the consent process was consistent with accepted clinical practice.

The Committee notes from the experts' joint report that they were unable to reach agreement on Charge 1. The point of dispute is whether the consent process UK GDC standards and the requirements of the Montgomery principle.

The Committee considered that the contemporaneous clinical records made on the day of appointment listed the risks of treatment in respect of both tongue-tie and lip-tie frenectomy. The Committee concluded that the entries in the contemporaneous records indicates that the risks of treatment were discussed with the parents of Patient A.

The Committee considered the contemporaneous record to be more reliable than the memories of all those giving statements two years after this appointment, which may have been affected by subsequent events and the passage of time.

	The Committee has also had regard to the extensive literature pack provided to the parents in advance of the treatment, which set out the risks and benefits, and which the parents said they had read in advance of treatment. On the balance of probabilities, the Committee concluded that you discussed with Patient A's parents the risks of the treatment in accordance with the GDC's standards and the requirements of the Montgomery principle. Accordingly, the Committee finds this charge not proved.
1b	*the treatment options* **Found not proved** Parent 1's evidence was "Alternative treatments were not discussed but the Registrant indicated a holistic approach should be taken which would help with overall recovery." Parent 1 accepted that the option of no treatment was discussed although he did not consider that 'no treatment' was an option. Dr Levinkind's position is that the option of not going ahead with the tongue tie procedure should have been explained to the parents. Your position is that the treatment options were discussed – the options were either to offer no treatment or release of the tethered oral issues. The Committee is satisfied that there were only two options – to proceed with the procedure or not to proceed. Both parents accepted that you told them of the risks to Patient A should they choose not to proceed with the treatment. The Committee is not satisfied, on the balance of probabilities, that the GDC has proved this charge to the requisite standard. Accordingly, it finds this charge not proved.
2	*You failed to obtain informed consent for the treatment for lip tie provided to Patient A on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all:*
2a	*The risks of the treatment* **Found not proved** Parent 2's evidence in respect of the lip tie procedure was that there was no discussion of the cons of a lip-tie procedure before, during or after the appointment. She further explained: "We received no literature or information on the lip-tie procedure." It was put to Parent 2 that you explained to her that the risks of a lip tie were almost identical to a tongue-tie, and in fact, that the risk was lower as the lips do not have the same tissues. Her response was: "Not to my recollection." Parent 2 was asked whether you had explained to them why you were suggesting the lip tie, she replied "No". She was further asked whether you had explained the rationale for carrying out the lip tie procedure, to which she replied, words to the effect of, "No, which is why we felt uneasy when reflecting afterwards." Parent 1's evidence on the lip-tie treatment was: "There was no discussion on the disadvantages of such a procedure but instead a focus on how quick, easy and helpful carrying out the lip-tie release at the same time as the tongue-tie procedure would be. We did not sign any consent form for this procedure, nor were provided any literature on

	it and did not discuss any alternatives. Neither were we told about costs for the lip-tie release." He maintained this position in his oral evidence and said "No, it was all about pros, no mention of negatives, that they were the same." You explained that upon clinical examination, you identified a tongue-tie and a lip-tie, together with lip blisters indicative of feeding and tongue dysfunction. You considered release of the lip tie appropriate in order to improve Patient A's ability to feed. You maintain that you explained to Patient A's parents that performing a lip-tie release at the same time would avoid a second procedure at a separate appointment, allow both sites to heal together, and reduce the period of aftercare. You said you also advised Patient A's parents that the risks of the lip-tie release were almost identical to tongue-tie, namely risks such as bleeding, discomfort and scar tissue formation, but have a lower risk than the tongue as the upper lip does not have the same risks with blood vessels, muscles and more prominent nerves. Your position is that after a discussion of risks and benefits, the parents elected for both tongue-tie and lip-tie release to be performed at that appointment. Dr Levinkind's opinion is that there was lack of consent for the lip-tie treatment. His position is that Patient A's parents were not informed of the limited evidence, thus affecting consent validity. In his oral evidence Dr Levinkind accepted that the risks of the lip-tie would be the same or less as that tongue tie treatment and that a lip blister was indicative of a lip-tie. However, in the joint report and in his oral evidence Dr Levinkind maintained that there was a lack of consent. Dr Baxter's position was that written and verbal consent was obtained prior to carrying out the lip-tie procedure and the consent process was consistent with accepted practice. The Committee has given significant weight to the contemporaneous clinical records for the reasons set out above. The entries in the clinical notes record the risks of treatment in respect of both the tongue and lip-tie frenectomy. This indicates that the risks of treatment were discussed with the parents of Patient A. The Committee concluded, on the balance of probabilities, that you discussed with Patient A's parents the risks of the treatment, in accordance with the GDC's standards and the requirements of the Montgomery principle. Accordingly, the Committee finds this charge not proved.
2b	*The treatment options* **Found not proved** The Committee is satisfied that there were only two options – to proceed with the procedure or not to proceed. Both parents accepted that you told them of the risks to Patient A should they choose not to proceed with the treatment. The Committee is not satisfied, on the balance of probabilities, that the GDC has proved this charge to the requisite standard. Accordingly, it finds this charge not proved.
2c	*The limited evidence base for the treatment* **Found not proved** The Committee has first considered whether there is a limited evidence base for the treatment of a lip tie in conjunction with the tongue tie.

	Dr Levinkind's opinion was that the contested nature of the evidence base for isolated lip-tie treatment is a material matter which a parent would want to know about before consenting. In the joint expert report and in his oral evidence Dr Levinkind's position changed in that he described the nature of the evidence base as "contested" rather than "limited". Dr Baxter disagrees with Dr Levinkind's opinion. His position is that the evidence base for lip-tie treatment is not accurately described as limited. In Dr Baxter's report he cited various studies in support of that contention, including Ghaheri 2017 and Slagter 2020 as showing the concomitant (at the same time) treatment of lip-tie and tongue-tie can have improved breastfeeding outcomes. He also cited two other studies - Freeman 2020 and Patel 2019 which showed that isolated lip-tie treatment can have positive breast feeding effects on babies. In his oral evidence Dr Baxter confirmed that the sample size was still considered to have some weight. The Committee has borne in mind Dr Levinkind's change of position from "limited" evidence to "contested" evidence and that in his oral evidence he talked about isolated lip-tie, whereas the treatment offered in this case was for both the tongue and the lip- tie procedures. Taking all these factors into account, the Committee did not find Dr Levinkind's evidence on this matter to be clear. It prefers Dr Baxter's evidence on this matter. Accordingly, it finds this charge not proved.
2d	*The cost of treatment* **Found proved** The parents' evidence was that there was no discussion of the cost of the lip-tie treatment. Your evidence is that you explained to Patient A's parents that treatment of both would cost the amount set out in the treatment plan and consent form, which they had signed. You also explained that it was your routine practice to explain to parents the cost of treatment at the appointment as you did not want them to experience any "surprises" when it came to paying for the treatment. The Committee notes that the literature pack provided in advance of the treatment set out of the cost of both types of treatment. However, the literature did not explain the term 'double release' and the Committee considered that it may not be clear to a lay reader that this related to both lip-tie and tongue-tie. In any event, it is accepted by all that the Parents 1 and 2 did not anticipate Patient 2 having a lip-tie when reading the literature pack. There is no indication in the contemporaneous clinical notes of a discussion of the cost of the lip-tie treatment. Both experts agreed that there was an obligation to discuss the cost of treatment with the patients and to document those discussions. In the absence of a contemporaneous clinical note about discussion of cost, from which the Committee has inferred that no discussion of costs took place, and having regard to the joint position of both experts that the cost of treatment should have been documented, the Committee finds this charge proved.
3	*You failed to obtain informed consent for the off-label use of a topical anaesthetic paste in Patient A's mouth on 27 January 2023, in that you did not discuss with Patient A's Parents, adequately or at all, the risks of using the paste intra-orally.* **Found not proved**

	The records for the appointment state: "Very small amount of EMLA 5% topical Lidocaine placed". Your evidence is that you told the parents that you would be using a topical cream intra-orally. The Committee has first considered whether there were risks using the EMLA Cream on the patient's mouth on that occasion. Dr Levinkind's position is that EMLA is not licensed by the MHRA for intra-oral use. Its use in an infant's mouth is therefore off-label. His evidence was that regardless of the amount of EMLA cream used intra-orally, this constituted off-label that required explicit discussion with the parents of the risks and justification for use. In his oral evidence, Dr Levinkind's primary criticism was that Parents 1 and 2 should have been told that the use of EMLA intra-orally is off-label, which is not the substance of the charge. He accepted that the cream was widely used in the tongue-tie clinical community at the time. He stated that there was no published guidance on its use in infant frenectomy and accepted that the risks are low. Dr Baxter's position is that EMLA cream was the standard topical anaesthetic used in tongue-tied procedures worldwide in 2022 and 2023. In his oral evidence Dr Baxter accepted that there were some risks in using EMLA, more so with babies, but described the risk as "miniscular" given small quantity used. The Committee has borne in mind that the thrust of Dr Levinkind's evidence is whether the specific UK regulatory obligations that accompany off-label prescribing are met. The Committee prefers Dr Baxter's evidence on this matter. His evidence is that there is no recorded occurrence of methaemoglobinaemia from the doses of EMLA cream used in frenectomy in an infant. He described the risk as "minuscular" given small quantity used. Dr Baxter referenced the 2020 study which demonstrated EMLA's use with ethics committee approval and without adverse events. The Committee is satisfied that the risks of using the Emal Cream on the patient's mouth on that occasion were so low that there was no obligation on you to have informed the parents of the risks involved in using the off-label use of the EMLA cream. Accordingly, it finds this charge not proved.
4	*You failed to obtain informed consent for the treatment provided to Patient A on 13 February 2023, in that you did not discuss with Patient A's Parents, adequately or at all:*
4a	*The risks of the treatment* **Found proved** The contemporaneous notes for the appointment state: "*MH:Checked* *O/E: There was some tension present on the tongue.* *Treament:Stretched out the frenum by hand to loosen it up again as some tension was present bleeding observed and controlled* *Discussion: Advised that Parentst massages vitamin E or Coconut oil in the area. Advised to continue with exercises for another 4 weeks.* *Informed parents that:* *She will be in some slight discomfort for upto 48 hours bach flowers can be used to aid in healing.*

Keep stretching the wound, to keep it elastic.
That a follow uo review in 2 weeks is vital to aid in assesment of the wound
Keep performing stretches,
Parents left happy"

Patient A's mother's evidence was that she understood that the purpose of this appointment was to examine Patient A's recovery after the initial treatment. On her account you explained to her and Parent 1 that you were going to have a look in Patient A's mouth and whilst looking you remarked that things were good but that you were going "to apply some pressure to release the wounds as it looked a bit tight. He then immediately proceeded to do so without any further conversation, discussion or even looking at us to seek our consent." Patient A's mother describes blood streaming from her daughter's mouth and Patient A was "screaming in visible pain."

She maintained this position in her oral evidence and described the incident as being "etched in my memory". She further described as "like a narration of what he was doing. Immediately – when it happened – no time at all to ask for our consent. No time for us to reply." She described crying at the end of the appointment and immediately complaining to the receptionist.

Patient A's father's account in his witness statement was as follows "The Registrant inspected my daughter and was initially positive, saying things were looking pretty good. He then indicated the tongue-tie was a little tight and that he was going to release it by applying some pressure to "pop it open". Without any further discussion regarding alternatives or the advantages and disadvantages of the procedure, and without signing any consent form or providing verbal consent. The Registrant went on to force his hands through my daughter's mouth, reopening the wound and releasing it by applying significant pressure. A lot of blood squirted out and the whole scene was very stressful."

Patient A's father maintained this position in his oral evidence. It was put to him that you told the parents what you were going to do and that one of the parents nodded, to which Patient A's father said "No, that didn't happen".

Your position is that you did not need to obtain informed consent at the follow up appointment as the stretch you performed was the same as that which the parents should have been performing at home and was not a separate procedure. You stated that the consent given for the initial procedures included consent for this follow up appointment. You accepted that some bleeding and discomfort was likely. However, your position is that in any event you discussed with the parents the risks of the stretching of the tongue and the lip which would open up the wounds. On your account, in your witness statement and in your oral evidence, you say that you told Patient A's parents what you were doing and you saw a nod in agreement which, you say, happened while the dental nurse was taking photographs, with her back to the parents.

The dental nurse also confirmed in her evidence that, in accordance with your usual practice, you would have checked with the parents to see if they were happy for you to go ahead with the manual stretch and you then performed this with your fingers.

Dr Levenkind's position is that the follow-up stretch on 13 February 2023 constituted a separate clinical intervention in its own right and caried a forceable risk – including the near certain risk of bleeding as reflected in the 90% figure. He considered that reliance on a 'nod' was not valid for a clinically significant intervention that would be uncomfortable and result in bleeding. He opined that the foreseeable risk of a baby's wound reopening

and bleeding is a material risk that a reasonable parent would want to be told about before the appointment.

Dr Baxter's position is that the follow up stretch on 13 February 2023 was part of routine post-operative management and fell within the scope of the consent given at the original procedure. In his opinion, the pressure applied was no greater than parents use when performing home stretches. Dr Baxter considered that specific consent documentation was not required.

The Committee has borne in mind that there is no contemporaneous record of you having had that discussion with the parents in advance of carrying out the procedure. The clinical notes refer to the after-effects of the procedure on Patient A.

The Committee noted that the parents of Patient A formally complained on the evening of the same day of the appointment by email. They set out their concerns as follows:

> *"At today's appointment Dr Suraj undertook a quick assessment of [Patient A] and, despite initial positive comments, told us that the wounds had healed quicker than expected and were tight. During this assessment he then said he was going to quickly release both wounds with his hands there and then. Before we could ask any questions and understand the implications of this, it had happened to both the tongue and lip wounds. We never gave our express permission at any stage nor were we offered the opportunity to ask questions before it was done. We had a brief chance to ask questions afterwards, over the cries of a screaming baby, at which point we were told we were "back to Day 1" from a recovery perspective. Dr Suraj has since called to say he needs to make a 'split second decision' to avoid reattachment but this is clearly not the case. The appointment was barely two minutes in - there was ample time to discuss this and then make a choice either way.*
>
> *What should have happened is that, once Dr Sura inspected and found that her wounds were tight, he should have spoken to us outlining the pros and cons of re-opening each of the respective wounds and the impact to recovery timelines. This would have allowed us time to ask questions and decide what was right for our child. We may for instance have decided that we wanted to delay doing this or that the tongue tie was worthy of reopening but not the lip tie. Dr Suraj has no knowledge of our wider lives and it is not his place to make a decision on our behalf. In addition, had we known that a manual release was set to take place, we would have ensured [Patient A] had had some pain relief prior to the appointment or immediately afterwards - as it stood, she was in real pain for hours afterwards before we were able to get her to take some Calpol. We know her pain cries - it was not painless as Dr Suraj described. I am not familiar with the medical ethics and legality of such matters but I simply do not believe it is appropriate to complete a procedure on a baby without the parents explicit permission. I would imagine this is not the sort of conduct you would expect either."*

There is no mention of you having explained what you were doing and/or that the parents had consented to the procedure by way of a nod in your email response to Patient A's mother or in your email dated 1 March 2023 to Patient A's father. Further, you did not assert this in your internal contemporaneous email discussion of the complaint with practice staff

The Committee has concluded that the manual wound re-opening on 13 February 2023, which you agreed carried a risk of bleeding, irrespective of whether this was a separate procedure, constituted treatment which required obtaining the informed consent of

	parents at that appointment. In coming to this conclusion, the Committee notes the expert evidence and the GDC's standards that consent is ongoing process. It was satisfied that the parents' evidence on this point was compelling and consistent with their contemporaneous complaint. By contrast, your evidence was not supported by the clinical notes or in your contemporaneous responses to the parents or Practice staff following the complaint to the Practice. It further considered that reliance on a nod would not amount to valid consent, particularly if it was not documented. The Committee is satisfied, on the balance of probabilities, that you failed to obtain informed consent for the treatment provided to Patient A on 13 February 2023. Accordingly, the Committee founds this charge proved.
4b	*The benefits of the treatment* **Found proved** This is for the same reasons as set out at charge 4a above.
4c	*The treatment options* **Found proved** This is for the same reasons as set out at charge 4a above.
5	*You failed to provide an adequate standard of care to Patient A on 13 February 2023 in that you reopened the wounds when this was unsafe given the passage of time since the initial procedures* **Found not proved** The main issue in dispute between the experts is whether manually re-opening a healing wound at 17 days was unsafe given the passage of time. Dr Levinkind's position is that this Head of Charge is supported by the evidence. He noted that at 17 days, post-procedure, oral mucosal healing was sufficiently advanced that deliberate manual reopening of the wound carried some risk of trauma, bleeding and pain to a young infant. He further opined that the clinical intervention was not justified by that stage of healing and the risks it carried out were not proportionate to the anticipated benefit. In his oral evidence Dr Levinkind set out that baby laser frenectomy wounds follow predictable patterns of healing patterns. This includes the proliferation stage where the tissues are re-organising and is likely to be far more dramatic in the first 7 to 14 days post treatment. He accepted that there is no formal guidelines, but explained that it is generally accepted practice that early review following a frenectomy, within seven days, is appropriate and manual wound re-opening in acceptable. However, manual wound opening more than 10 to 14 days after surgery was not recommended and the risks it carried were not proportionate to the anticipated benefit. Dr Baxter's evidence was that at 17 days post-procedure the wound had not fully healed and re-attachment was occurring. The intervention required only normal stretching pressure and the bleeding that occurred was minor and resolved with gauze pressure. He considered that the procedure was required to prevent re-attachment and optimise the outcome for the patient. Both experts agreed that you were acting in good faith to address a recognised complication of the original procedure.

	The Committee considered that Dr Levinkind appeared to reflect his own practice in these particular circumstances as opposed to what other clinicians might do. He accepted that you were in a better position to judge the risk and that it came down to clinical judgement. The Committee prefers Dr Baxter's evidence on this matter. It is not satisfied on the balance of probabilities, that the GDC has proved this charge to the requisite standard.
6	*You failed to maintain an adequate standard of record keeping in respect of Patient A's appointments on 27 January 2023 and 13 February 2023, in that you did not record, adequately, or at all:*
6a	*details of discussions around consent* **Found not proved in relation to 27 January 2023** **Found proved in relation to 13 February 2023** <u>27 January 2023</u> Dr Levinkind's opinion was that the clinical notes should have contained the consent details. He opined that each of the matters set out in the particulars of charge 6a to 6f were made out and together they represented a "systematic record keeping failure Dr Baxter accepted that there were some documentation shortcomings. However, he considered that not all of the sub-heads were made out to the extent alleged. The Committee has concluded from the records that informed consent was taken on 27 January 2023 for both the tongue tie and lip tie procedure. While the contemporaneous clinical record does not address consent directly, it does set out risks and justifications. The Committee concluded that the record of discussions of consent at this appointment is adequate. In these circumstances, the Committee finds that this not proved in relation to the 27 January 2023. <u>13 February 2023</u> For 13 February 2023, the Committee notes there are no details of discussions around consent, risks or justification in the contemporaneous clinical notes. It accepted Dr Levinkind's evidence on this matter. Accordingly, the Committee finds this charge proved.
6b	*justification for the treatment provided* **Found not proved in relation to 27 January 2023** **Found proved in relation to 13 February 2023** <u>27 January 2023</u> Dr Levinkind conceded that the notes were sufficient to justify the tongue tie procedure but "not entirely" in relation to the lip tie procedure. The Committee is satisfied that the notes set out the justification for both procedures and accordingly finds it not proved in relation to this appointment. <u>13 February 2023</u> The notes record: *"There was some tension present on the tongue. Treament: Stretched out the frenum by hand to loosen it up again as some tension was present bleeding observed and controlled"*

	However, based on the Committee's reading of notes, there is no reference in the clinical notes as to why you stretched the lip tie on 13 February 2023. It considers you should have recorded justification. Accordingly, it finds this charge proved.
6c	*Discussion of risks* **Found not proved in relation to the appointment on 27 January 2023** **Found proved in relation to the appointment on 13 February 2023** 27 January 2023 The Committee is satisfied that there is adequate note in relation to the risks of both the tongue tie treatment and the lip tie treatment. 13 February 2023 The Committee is satisfied that there is no record of the potential risks of bleeding of both the tongue-tie treatment and the lip-tie treatment.
6d	*Details regarding laser settings* **Found proved** You accepted that you did not record details regarding the laser settings. You explained that the equipment is usually set at the same settings which it reverts back to at the end of treatment. Dr Levinkind was critical of you not recording the laser settings. In his oral evidence he explained that it was general standard practice to record the laser settings as part of the patient records and in terms of understanding what setting has been used if the results are not what is expected. Dr Baxter's position is that recording the laser settings is ideal, but not essential. The Committee accepts Dr Levinkind's evidence on this matter. It is satisfied that there is a requirement for you to have recorded the detailing the laser settings in the patient records as they could assist with any future treatment of the patient.
6f	*Justification for the off-label use of a topical anaesthetic paste* **Found not proved** You recorded "Very small amount of EMLA 5% topical Lidocaine placed. -Tongue-tie" The GDC relies on Dr Levinkind's in support of this charge. He was critical of you not recording the justification for the off-label topical anaesthetic paste. In the light of the Committee not finding charge 3 proved, as well as well as Dr Levinkind's evidence that there are no guidelines about its use, the Committee finds this charge not proved.
7	*You failed to respond appropriately to complaints from Patient A's parents in that you*
7a	*Did not ensure a written response was sent in a timely manner* **Found not proved** Patient A's mother sent a formal to the Practice via email on 13 February 2023. You spoke to Patient A's mother on the telephone on 13 February 2023, unaware that a complaint

	had been made. You first became aware of the complaint on 16 February 2023. Parent 1 sent a chaser email on 21 February 2023. On that same day a member of the Practice reception team sent a holding email stating that the complaint had been forwarded to the Practice Manager and Founder when it came through and that they were reviewing the notes. The Practice Manager sent an email on your behalf dated 24 February 2023 to Patient A's parents which stated, among other things: "Unfortunately, you failed to attend for [Patient A's] appointment 2 times by rescheduling it, this resulted in reattachment of the ties." You personally sent a formal response to Parent 2's complaint dated 28 February 2023. You accepted that you could have ensured that a response was sent more promptly. In your evidence you explained that it was the first time you had to deal with such a complaint. You also maintain that you did not believe that you had done anything wrong. In support of this charge, the GDC relies on the evidence of Dr Levinkind. He was critical that there was an 8 day delay before acknowledging receipt of the complaint. In his report Dr Levinkind referred to a number of the GDC's standard of the GDC's "Standards for the Dental Team", including standard 5.2 which states: "You must make sure that there is an effective complaints procedure readily available for patients to use, and follow that procedure at all times." The Committee has not been provided with a copy of the Practice's complaints procedure and therefore it has no information regarding the timelines for responding to complaints, save for Dr Levinkind's opinion that an acknowledgement should have been provided within 8 days of the receipt of the complaint. The Committee has borne in mind that the Practice sent a holding reply on 21 February 2023, 5 days after you had learnt of the complaint. The Practice responded on your behalf 8 days after you had learnt about the complaint. The Committee considered that it was not unreasonable to have responded in that time frame. It is apparent from the exchange of emails between you and the Practice Manager that you were gathering information together and formulating a response to the parents during that intervening time. Accordingly, the Committee is not satisfied that this charge has been found proved to the requisite standard.
7b	*Reacted defensively to the complaint and/or did not offer an apology* **Found proved** Dr Levinkind was critical of your response to the patient's complaint in that no apology or real empathy was offered. In your oral evidence you accepted that with hindsight you may have been too defensive in your response to the complaint. The Committee has considered carefully the content and tone of your letter of response to the parents on 28 February 2023. In that email you stated, among other things, that the parents had "cancelled the follow-up appointment 2 times" and had not followed the protocol for the stretching exercises "for whatever reason". You did not appear to acknowledge or reflect on the upset and distress experienced by Parents 1 and 2 during the appointment on 13 February or the reasons for it. Instead, you appear to have taken the view from the outset that the parents were acting in bad faith.

	The Committee considers that you did not meaningfully engage with the parents' reasons for the complaint, which related to their perception that you did not obtain their informed consent for the lip tie and the tongue tie being re-opened and that you should have done so. In the Committee's judgement, the whole tenor of your reply is that you repeatedly sought to blame the parents, raising the cancellation of the follow-up appointment and asserting that they had not carried out the stretching exercises appropriately or at all. The Committee has concluded that the response was defensive in nature. The Committee interpreted the charge "did not offer an apology" to mean that you did not apologise, understanding the phrase 'offer an apology ' in the context of an everyday phrase which alludes to the ability of those being offered the apology to accept or reject the apology. The Committee notes that you sent an email dated 3 March 2023 to Parent 1 in which you state "I am happy to apologise for your experience." It noted this was in the context of requesting Parent 1 to remove their review. The Committee considers that this sentence does not amount to an apology and there is no evidence of an apology having been offered elsewhere. Accordingly, in light of the evidence before, the Committee is satisfied that this charge has been found proved.
7c	*Made the provision of a refund conditional on Patient A's father signing an 'agreement form' which stated:*
7ci	*"I agree and confirm my decision to agree to this release has not been influenced in any way by any representations of Dr Suraj Vatish* **Found proved** In reaching its decision the Committee has had regard to the "Agreement form" (undated) which sets out the particulars identified in charges 7ci to 7ciii. It has further had regard to your email dated 3 March 2023 to Parent 1 in which you proposed a 'gentleman's agreement' and to which you attached the "Agreement form" in question. In this email you set out what your expectations on Parent 1's side in order for you refund the fees. You told the Committee that you would have refunded the fees even if Parent 1 did not sign the agreement form and remove the review. However, there is no evidence that you communicated this to Parent 1 at any time. On the evidence before it, the Committee is satisfied that you made the provision of a refund of the conditional on Patient A's father signing the agreement form which contained the wording "*I agree and confirm my decision to agree to this release has not been influenced by any representations of Dr Suraj Vatish".* The Committee considers that it was wholly inappropriate to make a refund for treatment conditional on what is in effect a 'non-disclosure agreement', reflected in the wording of the Agreement. The Committee is satisfied that this was an inappropriate response to the Patient A's parents' complaint and find this particular proved.
7cii	*"I agree that I will keep the terms of this settlement and the facts pertaining to this matter confidential. I will not disclose any details to any external parties."* **Found proved** This is for the same reasons as set out at 7ci above.
7ciii	*"I agree to remove any reviews left on [Practice A's] dental pages."* **Found proved**

	This is for the same reasons as set out at 7ci above.
8	*In an internal email, dated 21 February 2023, you wrote:*
8a	*that Patient A's mother "has some of her own issues and health problems";* **Admitted and found proved**
8b	*that Patient A's Parents were "playing the system";* **Admitted and found proved**
8c	*that Patient A's Parents "mislead us".* **Admitted and found proved**
9	*Your conduct above*
9a	*In relation to Heads of Charge 7 and/or 8, failed to treat Patient A and their parents with dignity and respect* **Found proved in relation to Charges 7 and 8** <u>Charge 7</u> In relation to charge 7(b), the Committee concluded that by reacting defensively to the complaint and not offering an apology you failed to treat Patient A and their parents with dignity and respect. In relation to charge 7(c), Dr Levinkind's opinion was that making a refund conditional on a parent signing a statement that their decision was not influenced by the registrant, and a requirement to remove online patient reviews, represents a serious departure from the GDC's standards on complaints handling. Dr Baxter's position was that whilst the specific clauses in the proposed settlement agreement were not best practice and could have been handled more transparently, he considered that you were managing a complex and emotionally charged complaint. Both experts agreed that the specific clauses in the proposed agreement were poorly judged and inappropriate. The Committee has taken into account your evidence that this was the first time you had to deal with such a complaint. However, it considers that it was inappropriate and poor judgement for you to have made the provision of a refund conditional on Parent 1 signing an agreement form. It considered that you did not give sufficient regard to the distress caused to Patient A's parents or to the reasons for their complaint and you focused instead on your own experiences. Indeed, in your email to Parent 1 dated 1 March 2023 you stated: "This situation is equally stressful to myself and the team involved" and maintained this in oral evidence. The Committee is satisfied that your conduct in this regard amounted to a failure to treat Patient A and their parents with dignity and respect and was unprofessional <u>Charge 8</u> The Committee has heard from Parent 1 that they felt that you were not taking their complaint seriously. Regarding charge 8, Dr Levinkind's evidence was that the remarks made in the internal email dated 21 February 2023 failed to treat Patient A's with dignity and respect, failed to work with colleagues in a way that is in the patient's best interests, contravened expectations of respect and professionalism and contradicted the reflective tone in later remediation statements. He maintained this position in the joint report.

	Your position is that the matters set out in the email were in the context of private internal correspondence with colleagues at the Practice. You accept that you were not happy with the words you used and that it was not the language you should have been using. The Committee considers that the comments you made were designed to undermine the complaint by attributing blame to Patient A's parents, rather than help resolve their complaint in a constructive manner. It is satisfied that your conduct in this regard amounted to a failure to treat Patient A and their parents with dignity and respect and were unprofessional. This is regardless of whether the comments were made in the context of private internal correspondence.
9b	*In relation to charges 7 and/or 8, was unprofessional* **Found proved in relation to Charges 7(b), 7(c) and 8** This is for the same reasons as set out at charge 9(a) above.
9c	*In relation to charges 7(c)(i) and/or 7(c)(iii) was misleading* **Found not proved in relation to charge 7ci** **Found proved in relation to charge 7ciii** The Committee has had regard to the Agreement Form which sets out as follows "I [parent 1] (parent of Patient A) of sound mind and lawful age accept the refund of £810, as a goodwill gesture from Dr Suraj Vatish… I agree and confirm my decision to agree to this release has not been influenced in any way by any representations of Dr Suraj Vatish… I agree to remove any reviews left on [the Practice's] dental pages. I have carefully read this release and understand its contents, and I am signing it of own free will." The GDC puts its case that you the statement was misleading because you made representations in an effort to influence the father of Patient A to sign the agreement. Further, any decision to agree to the document would have been influenced by you in the context where you made the provision of a refund conditional on the form being signed. The Committee considers that the Agreement Form is asking the parents to declare they have not been influenced by representations made by you, not that no such representations have been made. Your representations offering a refund in exchange for signing this agreement are transparent within the form itself. It was open to the parents to choose not to sign the form and that was a decision for them to take on their own, without being influenced by you. Indeed the Committee noted that the parents did not sign the form. In these circumstances, while ill-judged and inappropriate, the Committee was not satisfied that the contents of the Agreement Form were misleading given that the representations made by you were clear, alongside the invitation to the parents to declare they had not been influenced in any way to agree to the release by those representations. **Found proved in relation to charge 7ciii** At charge 7ciii, the Committee has found that you failed to respond appropriately to complaints from Patient A's parents in that you made the provision of a refund conditional on Patient A's father signing an 'Agreement Form' which stated "I agree to remove any reviews left on Practice A's dental pages. The Committee considers that your actions were misleading in that you were seeking to secure the removal of a negative review, which reflected Parent 1's authentic experience,

	the effect of which would create a misleading impression to members of the public looking at reviews of the Practice.
9d	*In relation to charges 7(c)(i) was dishonest, in that you knew this was inaccurate.* **Found not proved** This is for the same reasons as set out at Charge 9(c) above. The Committee is satisfied that the provision of the refund being conditional is transparent within the document in itself.
9e	*In relation to charges 7(c)(iii) was dishonest in that you knew this would create an inaccurate impression of patient satisfaction* **Found proved** The Committee has considered first your state of mind at the time of the events in question. Your evidence is that you were not acting dishonestly and that you were unaware that a google review was directly linked to patient satisfaction. You explained that you felt that the review was "unjust" and that you were entitled to a public impression of patient satisfaction. The Committee has borne in mind that you knew that the parents of Patient A were not satisfied with the treatment. You therefore sought to have that negative review in return for offering them a refund. In the Committee's judgement, you knew that the removal of the negative review would create an inaccurate impression of patient satisfaction. It is further satisfied that your actions were dishonest according to the objective standards of ordinary decent people. The Committee has borne in mind that you knew that the parents of Patient A were not satisfied with the treatment and had seen fit to post a review. It took into account the positive personal testimonials which speak to your general good character. In its view, this evidence provided some weight to the credibility of your evidence and made it less likely that you would act dishonestly. However, a negative review having been posted, the evidence was clear that you sought to have the negative review removed in return for a refund of fees. In the view of the Committee, by making that offer, you knew that the effect of removing the review would affect the overall appearance of patient satisfaction on the practice website, in circumstances where the parents had not changed their opinion of their experience. The Committee rejected your assertion that you were unaware that the review would give an impression of patient satisfaction and did not consider it directly linked to patient satisfaction. If the offer been accepted, a negative patient experience would have been suppressed in return for a refund. The Committee was satisfied that ordinary decent people would regard seeking to suppress a negative patient review in this manner was dishonest by their objective standards.

34 We now move on to stage 2 of the proceedings

Proceedings at stage two

35 The Committee received the following documents at this stage of the proceedings:

- A copy of the Care Quality Commission's (CQC) Assessment Report dated 10 March 2026 of the Practice;
- A copy of Dental Nurse 2's witness statement dated 16 September 2025, who conducted an audit of your clinical notes on 18 August 2025;
- A copy of CQC's audit of tongue tie procedures covering the period from September 2025 to December 2025.

36 In accordance with Rule 20, the Committee heard submissions from Mr Mansell on behalf of the GDC and those made by Mr Colman on your behalf.

37 Mr Mansell confirmed you have no previous fitness to practise history. He submitted that the facts found proved are serious and fell short of what would be judged to be proper in the circumstances and amount to misconduct. He referred to the Committee's findings in relation to your failure to obtain informed consent for the treatment provided to Patient A, a three month old baby, on 27 January 2023 (in relation to the cost of the lip-tie treatment) and on 13 February 2023 (including the risks and benefits of the treatment and the treatment options) in circumstances where it was highly likely that the procedure would cause bleeding. He also submitted that your failure to maintain an adequate standard of record keeping in various areas regarding Patient A's appointment on 13 February 2023 as well as your failure to respond appropriately to Patient A's parents' complaints was serious. This included that you reacted defensively to the parents' complaint and you did not offer them an apology, as well as you making disparaging comments about Patient A's parents in an internal email dated 21 February 2023. Further, Mr Mansell submitted that the finding that you made the provision of a refund conditional on Patient A's father signing an 'Agreement Form' which had been found to be misleading and dishonest, was particularly serious. He invited the Committee to have regard to the experts' evidence as to whether the findings amounted to a falling short of the standards expected of a registered dentist.

38 Mr Mansell cited a substantial number of the GDC's "Standards For the Dental Team" (September 2013) which, he submitted, may apply in this case. In short, the GDC's position is that the findings against you fell short of what would be expected of a registered dentist and would be regarded as deplorable by fellow practitioners. They therefore amount to misconduct.

39 In respect of current impairment, Mr Mansell invited the Committee to take into account your past misconduct, the steps you have taken to remedy it and whether it is highly unlikely to be repeated. Mr Mansell acknowledged the evidence which demonstrates the work you have undertaken to improve your practice in areas such as your record keeping and consent. However, Mr Mansell submitted that you have shown a "severe" lack of insight into the matters engaged in this case. He cited examples of your responses in your evidence in support of that contention. He submitted that you have demonstrated a "cavalier" attitude and a lack of respect towards Patient A's parents' autonomy. It was Mr Mansell's submission that given the severe lack of insight demonstrated in this case, there remains a risk of repetition.

40 In short, the GDC's position is that the Committee cannot be satisfied as of today that you have addressed the areas of concern. Mr Mansell submitted that a finding of current impairment is necessary for the protection of the public. He further submitted that a finding of current impairment is necessary on the grounds of the public interest given the serious nature of findings against you.

41 Mr Mansell referred to the mitigating and aggravating features in this case. He submitted that the appropriate sanction is to direct an order of suspension for a period of six months with a review to take place before the expiry of the order. He submitted that this sanction was sufficient to mark the seriousness of the misconduct and also allow you further time to reflect on your misconduct.

42 Mr Colman addressed the Committee on each of the findings in this case which can be grouped as follows – consent, record keeping, complaint handling and dishonesty. He referred to Appendix A of the GDC's previous fitness to practise guidance case which provided information on the matter of consent (which is not present in the current 2026 Guidance). The previous guidance set out the starting point which the PCC should consider, including whether there was a failure to meet the standards of registrants, whether the failure was an isolated incident by a registrant who otherwise practised safely and whether any deficiencies in practice may have been remedied. He submitted that this was a single course of treatment, which does not reflect your wider practise, there being no other instances of consent failings either before or since this incident. Regarding the omission of cost discussions, this was not an attempt to profit and there is no suggestion of financial motivation. Mr Colman also referred to the steps you have taken to change your practice in the area of consent such that there is no current impairment in that regard.

43 Mr Colman invited the Committee to conclude that the record keeping shortcomings, set out at charges 6a and 6c cannot amount to misconduct. This was given the Committee's finding that there were no discussions around consent or risks on 13 February 2023. It would follow that you would have not recorded a discussion that did not take place. It was Mr Colman's submission that in respect of charge 6b, namely the failure to record the justification for re-opening the lip-tie wound on 13 February 2023, neither that charge alone, nor in combination with the failure to record laser settings in Charge 6d, would be considered deplorable by fellow professionals so as to amount to misconduct. Mr Colman submitted that Dr Levinkind was not clear that these failings were far below the expected standard.

44 Regarding the complaint handling and the dishonesty, Mr Colman referred the Committee to your statement on this matter, as well as the CPD you have undertaken on complaints and communication training. Mr Colman reminded the Committee of the Joint expert report in which both experts agreed that managing families whose babies require treatment for tethered oral tissues can be clinically and emotionally challenging, and that this was a complex and difficult complaint for you to handle. Both experts further agree that the specific clauses in the proposed settlement agreement were poorly judged and inappropriate. You attempted to resolve the matter directly without legal advice. Both experts consider that this was a one-off error of judgment in a stressful situation rather than evidence of a pattern of behaviour. The Committee has been advised that you have since undertaken remedial training in complaint handling in that you now send no response before consulting your indemnity provider and getting your reply approved by them, as well as the practice manager and the patient experience manager.

45 Mr Colman submitted there have been no further complaints and no repetition of the dishonesty. Further, this was not a dishonest attempt to gain financially but where you were attempting to protect your reputation. It was submitted on your behalf that that dishonesty is wholly out of your character and there will be no repetition.

46 However, Mr Colman recognised that the wider public interest can require a finding of impairment and a regulatory response given the findings against you.

47 Mr Colman submitted that were the Committee to conclude that your fitness to practise is currently impaired, then it would be sufficient and appropriate to conclude the case with an order of conditions. This could include imposing conditions that reflect and enforce the systematic changes that you have made to address any patient complaints. This could further include a requirement that you should not respond to any complaint without seeking legal advice and that any response must first be approved by your Practice Manager and Patient Experience Manager before being sent to the patient. Such a sanction would balance the need to maintain public confidence in the professional and to uphold proper standards of conduct and behaviour, while allowing you to continue to practise.

48 Mr Colman submitted that in the event that the Committee was minded to conclude this case with an order of suspension, a shorter period of suspension would adequately address the public interest considerations in this case.

49 The Committee has considered the submissions carefully. It has accepted the advice of the Legal Adviser. Throughout its deliberations, the Committee has had regard to the GDC's Guidance.

Misconduct

50 The Committee has considered the findings against you. It has grouped its findings under the following headings.

Consent (charges 2d and 4)

51 In respect of Charge 2d, (regarding a failure to discuss with Patient A's parents adequately or all the cost of treatment on 27 January 22023, the Committee considers that Patient A's parents did not have the clarity about the cost of the lip-tie treatment, which amounted to an extra £105. The Committee recognises that obtaining informed consent is a cornerstone of the public interest and a failure to do so in a serious matter. However, it concluded that this omission amounted to an oversight in the context of a conversation with Patient A's parents about the overall risks and treatment options for the lip-tie procedure. It was not, in the Committee's judgement, a deliberate attempt to profit from Patient A's parents. The Committee is not satisfied that this omission is sufficiently serious to amount to misconduct.

52 Regarding Charge 4, the Committee acknowledges that you were trying to do your best for Patient A in re-opening the wounds at the appointment on 13 February 2023. However, you were aware that carrying out this action was more than likely to cause bleeding in Patient A's mouth and that this could be stressful to the parents watching this happening to their baby. There were anticipated risks for Patient A and the parents should have been warned of this and given an opportunity to decide whether they wanted you to proceed. The Committee considered from your evidence that you do not appear to have appreciated that you needed to consult with Patient A's parents before embarking on the procedure. The Committee has accepted Dr Levinkind's opinion that these matters amounted to a falling far below acceptable standards. It considers that you failed to meet the standards expected of a registrant and that this is sufficiently serious to amount to misconduct.

Record keeping (charge 6)

53 The Committee found (Charge 4) that there were no discussions around consent or risks or benefits of treatment on 13 February 2023. It considered that the failure in respect of charges 6a and 6b to keep an adequate record flowed from the failure to discuss the matters found proved in relation to charge 4. The mischief therefore centred around the latter charge and the failure to keep adequate records added nothing to it. Dr Levinkind was not clear that these failings were far below the expected standard. The Committee does not think the record keeping failures in respect of this appointment adds to the overall seriousness and therefore it is not satisfied that these failures, either alone, or in combination with a failure to record the laser settings in Charge 6d, are sufficiently serious to amount to misconduct.

Complaint handling (charges 7, 8 and 9)

54 The Committee considers that as a registered dentist it was part of your responsibility to deal with complaints properly and professionally. It recognises, as did both experts, that managing families whose babies attend for treatment of tethered oral tissues can be clinically and emotionally challenging. The experts observed that In this case you attempted to handle a difficult complaint

without legal advice. Nevertheless, the Committee considered that you failed to understand or address the reasons for their complaint, as apparent by your email responses to Parent 1. The Committee has seen from Parent 2's emails that he was frustrated by your responses and removed his wife (Parent 1) from the emails as she was so upset by the situation. Rather than trying to find a solution to the issue you instead reacted defensively by seeking to undermine the parents. There was no attempt to understand the parents' experience, no empathy shown and no attempt to resolve their complaint in a constructive manner.

55 Furthermore, in an internal email dated 21 February 2023 you made disparaging comments about the parents. The Committee accepts that you yourself did not copy the parents in on the email and that you thought you were exchanging in privately within the practice. However, the Committee considers that the content and tone of the email seeks to blame and undermine the parents rather than trying to resolve their complaint. The Committee takes a serious view of the way in which you dealt with the parents' complaint. It is satisfied that your conduct in this regard, which the Committee found amounted to a failure to treat the parents with dignity and respect as well as being unprofessional, would be regarded as deplorable by fellow practitioners and amounts to misconduct.

Dishonesty (charge 9)

56 The Committee has taken into account that this was the first time you had a complaint and that you were trying your best to handle a situation without legal advice. Both experts agreed that the specific clauses in the proposed settlement agreement were poorly judged and inappropriate. The Committee considers that dishonesty in a professional is inherently a serious matter. You were fully aware that the parents of Patient A were not satisfied with the treatment. You therefore sought to have that negative review removed in return for offering the parents a refund. In the Committee's judgement, you knew that the removal of the negative review would create an inaccurate impression of patient satisfaction. The Committee is clear that your opinion that the parents' review was "unjust" was no justification for trying to get Parent 2 to remove the review which was an authentic reflection of Parent 2's level of satisfaction, in exchange for a refund. Being honest is a fundamental requirement under the Standards. Notwithstanding that this was a one off lapse of judgement, for which there is no suggestion of direct financial gain, the Committee is satisfied that its finding of dishonesty would be regarded as deplorable by fellow practitioners and amounts to misconduct.

57 In considering whether any or all of the facts found proved amount to misconduct, the Committee had regard to the following principles from the GDC Standards For the Dental Team (September 2013), in particular:

Standard 1.3: You must be honest and act with integrity.

Standard 1.3.1: You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them.

Standard 1.3.2: You must make sure you do not bring the profession into disrepute.

Standard 1.7: You must put patients' interests before your own or those of any colleague, business or organization.

Standard 2.3: You must give patients the information they need, in a way they can understand, so that they can make informed decisions.

Standard 2.4: You must give patients clear information about costs.

Standard 3.3: You must make sure that the patient's consent remains valid at each stage of investigation or treatment.

58 Accordingly, the Committee has concluded that the findings against you in relation to charges 4, 7, 8 and 9 each amount to a falling short of what would be expected in the circumstances and that such falling short is serious. It is satisfied that the findings against you amount to misconduct.

Committee's decision and reasons on impairment

59 The Committee next considered whether your fitness to practise is impaired by reason of misconduct on the grounds of the protection of patients and/or is in the wider public interest.

60 The Committee has borne in mind the steps you have taken to address the failings in this case. You set out your written reflections in respect of each of the areas identified in this case. You explained that what you have learnt from this process is that even when you provide detailed information packs, videos, and in-person explanations, there are always opportunities to make communication clearer and to ensure that families fully understand what is planned.

61 You explained in your written reflections that you have strengthened your consent and communication systems. You are in the process of adopting Iconsent software, which, you say, creates a clear, digital record of risks, benefits, and alternatives. You explained that this complements the information you already provide and ensures that parents have ongoing access to what you discussed. You say you now routinely confirm understanding by asking families to explain back the key points in their own words, which helps you check that information has been absorbed and reduces the risk of misunderstanding. In addition, you say that you now offer pre-appointment virtual consultations purely for discussion and questions. You explained that this process allows families to clarify any concerns before coming into the clinic and gives them time to reflect on their options without the pressure of an imminent procedure. Further, you set out that you have adjusted your follow-up arrangements so that families are now routinely offered two review appointments if required. Both experts noted that you have "implemented a digital consent system which is admirable".

62 You further set out that alongside this, you have undertaken Continuing Professional Development (CPD) specifically on communication, consent and professional obligations under the GDC Standards. You explained that these courses have helped you refine how you present information, how you checked patients' understanding and how you record discussions in the clinical notes.

63 The Committee recognises the steps you have taken to address the concerns in this case in the areas of record keeping and complaints handling. This is supported by the CQC audit of your practice which indicates that record keeping has improved since the events in question. During the course of your evidence you accepted that could have handled the complaint differently. The Committee considers that you have shown insight into the need for improved systems and support in complaints handling.

64 The Committee considers that you have acted on that insight by putting systems in place so that others assist you in complaint handling. However, the Committee considers that you have shown insufficient insight into the fact that the way in which you treated Parent 1 and 2 following their complaint lacked empathy, was disrespectful and wholly unprofessional or the extent to which your response fell short of expected standards. Further, the Committee does not consider you have shown any insight into the impact on Parent 1 and 2 of your unprofessional, disrespectful and dishonest response to their legitimate complaint about your failure to take informed consent for the treatment of their daughter on 13 February 2023. As a consequence, the Committee considers that the risk remains of you responding to patient concerns without sufficient regard to their perspective, irrespective of the improved systems in place.

65 Turning to the matter of informed consent, the Committee has noted that you have undertaken several training courses on consent. It has borne in mind that you have implemented a digital consent system as part of improving your practice. The Committee is encouraged by the steps you have taken. Nevertheless, the Committee was concerned about your responses in your evidence regarding the consent process. It is not satisfied that you appreciate fully that informed consent is an ongoing process which requires ongoing discussions with the parents of a baby for any intervention with associated risks. Notwithstanding the practical steps you have put in place, the Committee is not confident, based on your limited insight on this matter, that the consent failings have been addressed. The Committee has therefore concluded that there remains a risk of repetition of the concerns relating to patient consent.

66 Regarding its finding of dishonesty, the Committee accepts that it was an isolated incident, relating to what was in effect a 'Non-Disclosure agreement'. The Committee has taken into account the testimonials submitted on your behalf which speak to your otherwise good character. The Committee accepted your evidence that under no circumstances in the future would you use such an agreement, offering a refund in exchange for securing the removal of a review and confidentiality. It considered that your conduct was an uncharacteristic lapse of judgement in a challenging situation and falls at the lower end of the spectrum of dishonesty. Taking all these factors, the Committee has concluded that the risk of repetition of your dishonest conduct is very low.

67 However, in the light of the Committee's findings about the risk of repetition in relation to the management of complaints and informed consent, it has determined that a finding of current impairment on the grounds of misconduct is necessary to protect members of the public.

68 Turning to the wider public interest, the Committee is mindful of the serious nature of the multiple findings against you, which include matters relating to obtained informed consent for a three month old baby as well as complaints handling. It has also found you to have acted dishonestly. It considers that your dishonest conduct falls at the lower end of the spectrum of dishonesty. Nevertheless, a finding of dishonesty is serious and of itself is likely to give rise to a finding of current impairment, as set out in paragraph 230d of the Guidance. Given the multiple findings against you, the Committee has concluded that a finding of current impairment in relation to your misconduct is necessary on the grounds of the public interest. It considers that public confidence in the dental profession would be undermined if a finding of impairment were not made.

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

Committee's decision and reasons on sanction

70 The Committee then determined what sanction, if any, would be appropriate in light of the findings of facts, misconduct and current impairment that it has made. The Committee recognises that the purpose of a sanction is not punitive, although it may have that effect, but is instead imposed in order to protect patients and safeguard the wider public interests. In reaching its decision the Committee has again taken into account the GDC's Guidance. It has applied the principle of proportionality, balancing the public interest with your own interests.

71 The Committee has considered the mitigating and aggravating factors present in this case. In terms of mitigating factors, the Committee has noted the following:

- You have no fitness to practise history;
- You have taken remedial action over a sustained period of time;
- There is no evidence of repetition.

72 In relation to aggravating factors, the Committee has borne in mind the following:

- Stress and upset caused to the parents of Patient A ;
- Insight is not sufficient in relation to the matters of informed consent and the need to treat patients with dignity and respect when handling patient concerns.

73 The Committee has had regard to its previous findings on misconduct and impairment in coming to its decision and considered each sanction in ascending order of severity.

74 The Committee first considered whether to impose no order or to issue a reprimand. However, it rejected these courses of action on the basis that they would not be sufficient to protect the public, nor would it be in the public interest, to allow you to continue to practice without some form of restriction in place.

75 The Committee then considered whether placing conditions on your registration would be a sufficient and appropriate response to address the risks identified in this case. Any conditions that may be formulated must be workable, measurable, enforceable and address the risks that have been identified. It has taken into the submissions made on your behalf that conditions could be imposed that reflect and enforce the systematic changes you have made to your practice, with particular regard to the way you will address any patient complaints. While noting the progress you have made, the Committee considers that you currently lack sufficient insight into the importance of obtaining ongoing informed consent and the need to treat patients with dignity and respect when handling patient concerns. It considers that conditions are unworkable because of its concerns about current level of insight.

76 In addition, given the finding of dishonesty in this case, albeit at the lower end of the spectrum of seriousness, the Committee concluded that conditions would not adequately address the public interest in this case and would not adequately uphold public confidence in the profession.

77 The Committee then went on to consider whether a suspension would be the appropriate sanction. Paragraph 277 of the GDC's Guidance states that suspension may be suitable where most of the following factors are present:

- the registrant has not shown insight into the issues which led to a finding of current impairment being made, and/or poses a significant risk of repeating the behaviour;
- a lesser sanction would be insufficient to meet the public interest.

78 The Committee has had regard to the dishonesty found proved in this case, It has borne in mind that it was a one-off incident that was not committed for direct financial gain and was an uncharacteristic lapse in a challenging situation. There is no evidence of repetition of similar conduct, either before or since the incident. The Committee was satisfied that the misconduct in this case was not fundamentally incompatible with remaining on the register. The Committee considered that a short period of suspension of four months would give you sufficient time to reflect on your misconduct and to develop sufficient insight into it in order to be able to practise safely.

79 The Committee did go on to consider erasure but, taking into account all of the information before it, and the mitigation provided, determined that it would be disproportionate and unduly punitive.

80 Balancing all these factors, the Committee directs your registration be suspended for a period of four months. The Committee is satisfied that this period of time is necessary, sufficient and proportionate in order for you to reflect further whilst sending the public and the profession a clear

message about the standards of practice required of a dentist. The Committee noted the hardship the suspension may cause you, however this is outweighed by the public interest in this regard. The Committee further considers that this period of time is sufficient to protect patients and to maintain and uphold public confidence in the profession.

81 The Committee directs that this order be reviewed before its expiry, and you will be informed of the date and time in writing. The reviewing Committee will consider what action it should take in relation to your registration following an assessment of the concerns affecting your fitness to practise.

82 The reviewing Committee may be assisted to receive:

> *A detailed reflective statement demonstrating your insight into and understanding of why your practice of informed consent and complaint handling was found in this case to be below the accepted standard of a dentist. You may wish to outline what you should have done differently, the impact of your failings on the parents of Patient A and the reputation of the profession. You may wish to further outline how you will avoid a repetition of your failings in the future.*

83 The Committee now invites submissions as to whether the suspension should take immediate effect to cover the 28-day appeal period.

Decision on immediate order

Mr Vatish

84. Mr Mansell confirmed that there is no interim order currently on your registration. He made an application for an immediate suspension order to be imposed on your registration under Section 30(1) of the Dentists Act 1984. He submitted that an order is necessary on the grounds of public protection and the public interest in light of the Committee's findings at the impairment and sanction stage. He cited the risks of repetition identified by the Committee in its determination.

85. Mr Colman submitted than the risk is not so pressing or so grave as to a warrant an immediate suspension order. He made the point that there has been no interim order in the period of over three years since this complaint was made, and you have been practising without any repetition of the events in question. Further, Mr Colman submitted that an immediate order would significantly extend the period of suspension by at least an additional 25%, rendering it disproportionate. In short, Mr Colman submitted that an immediate order is neither necessary nor desirable.

86. The Committee has considered the submissions carefully. It has accepted the advice of the Legal Adviser, who drew its attention to paragraph 285 onward of the GDC's "Fitness to Practise: Guidance for the practice committees" which deals with immediate orders.

87. The Committee determined that the imposition of an immediate order of suspension on your registration is necessary for the protection of the public. In reaching its decision, the Committee has already identified that your insight into your misconduct in relation to consent and complaint handling is still developing and there remains a risk of repetition. Consequently, the Committee has determined that there is an ongoing risk of harm to the public.

88. However, the Committee is not satisfied that immediate action is required to maintain public confidence in the profession. It is satisfied that the four month period of suspension is sufficient to maintain public confidence in the professions for the reasons set out in its previous determination.

89. The Committee took into account that in the absence of an immediate order, you could return to unrestricted clinical practice during the 28-day appeal period, or for potentially longer, in the event of an appeal. An immediate order is therefore necessary to protect the public.

90. The effect of this immediate order is that your registration is now suspended. Unless you exercise your right of appeal, the substantive direction of suspension for a period of four months will replace the immediate suspension upon the expiry of the 28-day appeal period. Should you exercise your right of appeal, this immediate order shall remain in force pending the resolution of the appeal.

91. That concludes this determination.