Dental Professionals Hearings Service

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

21 July – 1 August 2025
19, 22 and 26 September 2025
21 November 2025
12 and 13 February 2026

Name:	HORRI, Elena
Registration number:	291568
Case numbers:	CAS –206633-C5X9B1 CAS –207883–H0Y2Z5

General Dental Council:	Mr Omar Soliman, Counsel. Instructed by Carly Smith, IHLPS
Registrant:	Not Present Unrepresented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased
Immediate order:	Immediate suspension order

Committee members:	Diane Meikle (Lay) (Chair) Gezala Umar (Dentist) Stephanie Carter (Dental Care Professional)
Legal Adviser:	Alain Gogarty
Committee Secretary:	Andrew Keeling

CHARGE

HORRI, Elena a dentist, DDM Medical University - Sofia 2017 is summoned to appear before the Professional Conduct Committee on 21 July 2025 for an inquiry into the following charge:

"That being a registered dentist:-

Patient A: Clinical

1. *You failed to provide an adequate standard of care to Patient A between 7 May 2022 and 30 May 2022 including by/in relation to:*

    a. *Not carrying out sufficient diagnostic assessments in that you did not conduct a cosmetic assessment of the upper anterior teeth.*

    b. *Not carrying out sufficient treatment planning.*

    c. *You provided a poor standard of treatment in that the composite bonding:*

        i. *Was poorly contoured,*
        ii. *Had a superficial layer poorly bonded to the underlying layer,*
        iii. *Had an initial shade that was too dark,*
        iv. *Had margins that were rough/uneven/overhanging,*
        v. *Was poorly polished.*

2. *You failed to obtain informed consent for the treatment provided between 7 May 2022 and 30 May 2022 in that:*

    a. *You did not provide Patient A with all treatment options.*
    b. *You did not discuss the cost of treatment at the second visit.*
    c. *You filed UR3, UR4, UL3, UL4 without Patient A's consent.*

3. *You failed to respond adequately to Patient A's complaints about:*

    a. *Being charged a further £1080 for treatment,*
    b. *The remedial treatment.*

4. *You failed to treat Patient A with kindness and compassion, including by:*

    a. *Shoving/pulling her head down on the bed,*
    b. *Laughing in her face stating you 'got what you asked for' or words to that effect,*
    c. *Leaving her alone whilst undergoing tooth whitening.*

5. *You provided dental treatment without adequate support.*

6. *Your actions in respect to 4c and/or 5 put Patient A's safety at risk.*

Patient A: Dishonesty

7. *On 30 May 2022, you charged Patient A's account without her consent to do so.*

8. *Your conduct in respect of 7 was dishonest in that you knew you did not have Patient A's consent to charge her account.*

9. *On 15 November 2023 you provided, via your lawyers, the following documents to the GDC:*

    a. *A patient questionnaire signed 05 May 2022 with a submission date of 17 May 2022*
    b. *A patient questionnaire signed 07 May 2022 with a submission date of 07 May 2022*
    c. *A patient questionnaire signed 17 May 2022 with a submission date of 17 May 2022*
    d. *A patient questionnaire signed 05 July 2022 with a submission date of 07 May 2022*
    e. *A consent form signed 17 May 2022 with a submission date of 17 May 2022*
    f. *Transcript of WhatsApp chat with Patient A*
    g. *Patient treatment records dated 7 May*
    h. *Patient treatment records dated 17 May*

10. *Your conduct in relation to 9a, 9b, 9c, 9d, 9e, above was:*

    a. *Misleading,*

b. Dishonest, in that the records purport to have been completed by Patient A but in fact were completed and/or edited by you.

11. Your conduct in relation to 9f was dishonest in that the entry in Schedule 1[1] purporting to be from Patient A was in fact made by you.

12. Your conduct in respect of 9g and 9h was:

a. Misleading,
b. Dishonest, in that you have represented that the records relate to Patient A when they do not.

In the alternative to charge 12:

13. You failed to maintain an adequate standard of record keeping between 07 May 2022 and 30 May 2022 in that:

a. You recorded that Patient A's first appointment was on 7 May when in fact it was on 17 May,
b. You recorded that Patient A's second appointment was on 17 May when in fact it was on 30 May,
c. You did not record that you performed tooth whitening,
d. You recorded that you used the same shade at both appointments, when in fact you used different shades,
e. You did not record that you filed UR3, UR4, UL3 and UL4.

Patient B

14. You failed to provide an adequate standard of care to Patient B on 26 January 2022 in that:-

a. *You did not undertake any or any adequate medical history from Patient B;*
b. *You did not undertake any or any adequate assessment of Patient B's Covid-19 status;*
c. *You did not undertake any or any adequate occlusal assessment;*
d. *You provided a poor standard of composite bonding to Patient B's UR1 in that:-*

i. *The UR1 was bonded to the UL1,*
ii. *The composite bonding:-*

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

a. *Was poorly contoured*
b. *Was of a poor aesthetic result*
c. *Had overhanging margins*
d. *Left Patient B with bite problems*
e. *You provided a poor standard of composite bonding to Patient Bs UL1 in that:-*

i. *The UL1 was bonded to the UL2*
ii. *The composite bonding:-*

a. *Was poorly contoured*
b. *Was of a poor aesthetic result;*
c. *Had overhanging margins*
d. *Left Patient B with bite problems*

15. On 29 March 2022 you sent an email to Patient B accusing her of acting with "bad intent" and threatening legal action for raising a complaint.

16. Your conduct in relation to 15 above:-

a. *Unprofessional*
b. *Failed to respect Patient B's right to complain.*

CQC

17. As practice principal you have failed to register the following locations with the Care Quality Commission:

a. [Redacted]
b. [Redacted]

And, that by reason of the facts alleged, your fitness to practise is impaired by reason of misconduct."

1. This is a Professional Conduct Committee (PCC) hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Microsoft Teams in line with current General Dental Council (GDC) practice.

2. Ms Horri was not present at the hearing and not represented in her absence.

3. Ms Amy Woolfson, Counsel, appeared as Case Presenter on behalf of the GDC.

Preliminary matters

4. At the commencement of the hearing, the Committee considered the following applications in accordance with Rule 17 of the *'General Dental Council (Fitness to Practise) Rules Order of Council 2006',* referred to hereafter as 'the Rules'.

Decision and reasons on Notice of Hearing

5. The Committee noted at the start of this hearing that Ms Horri was neither present nor represented at today's hearing.

6. In her absence, the Committee first considered whether the Notice of Hearing ('the Notice') had been served on Ms Horri in accordance with Rules 13 and 65. The Committee heard and accepted the advice of the Legal Adviser in this regard.

7. Ms Woolfson, on behalf of the GDC, referred the Committee to the indexed *'Service bundle'* of 16 pages, which contained a copy of the Notice, dated 16 June 2025. The Notice was sent to Ms Horri's registered address by International Track and Signed and International Standard Delivery on 16 June 2025, in accordance with Section 50A of the *'Dentists Act 1984 (as amended)'*, referred to hereafter as 'the Act'. The Notice was also sent to Ms Horri's registered email address on the same date.

8. The Committee was satisfied that the Notice contained proper and correct information relating to today's hearing. This included the time, date and that it is being conducted remotely via Microsoft Teams, as well as notification that the Committee has the power to proceed with the hearing in Ms Horri's absence. The Committee was also satisfied that the Notice has been sent to the postal address and email address that the GDC has on file for Ms Horri.

9. In light of the information available, the Committee was satisfied that Ms Horri has been served with proper notification of this hearing, with at least 28 days' notice, in accordance with the Rules.

Decision and reasons on proceedings in the absence of Ms Horri

10. The Committee next considered whether to exercise its discretion to proceed with the hearing in the absence of Ms Horri and any representative on her behalf. The Committee was mindful that its decision to proceed in the absence of Ms Horri must be handled with the utmost care and caution. The Committee heard and accepted the advice of the Legal adviser in this regard.

11. Ms Woolfson referred the Committee to the indexed *'Proceeding in absence bundle',* comprised of 43 pages. She informed the Committee that the GDC has received two emails from Clyde & Co dated 5 June and 2 August 2024, confirming that it is no longer representing Ms Horri regarding these matters and directing the GDC to correspond directly with Ms Horri in relation to these proceedings.

12. Ms Woolfson then referred the Committee to a number of documents showing the attempts made by the GDC to contact Ms Horri directly, including the provision of letters, telephone attendance notes and emails. She stated that the GDC had directed Ms Horri to provide any observations regarding the final allegations and supporting documentation by the deadline of 15 May 2025, but none had been received. Further, Ms Woolfson stated that Ms Horri did not respond to or attend the telephone conference call for the Hearings Case Management Meeting, arranged for the GDC lawyer, the Case Presenter, and the registrant, on 14 February 2025.

13. Ms Woolfson directed the Committee to the table of documents sent to Ms Horri and indicated that a number of the documents emailed to Ms Horri had been downloaded. However, she confirmed that Ms Horri has not contacted the GDC regarding this case.

14. The Committee noted that the email address being used by the GDC is one that has been used by Ms Horri on previous occasions to correspond with the GDC. The Committee was satisfied that there has not been any engagement by Ms Horri in relation to today's hearing and, as a consequence, there was no reason to believe that an adjournment would secure her attendance on some future occasion. Ms Horri has not requested an adjournment of these proceedings and there was no evidence that doing so would guarantee her engagement and attendance on some later date.

15. The Committee bore in mind that today's hearing has been arranged within a reasonable time of the allegations and any further delay would unnecessarily prevent the expeditious consideration of this case.

16. On this basis, the Committee concluded that Ms Horri had voluntarily absented herself from today's hearing.

17. In all these circumstances, the Committee determined that it was fair and in the public interest to proceed with the hearing in the absence of Ms Horri.

Charges

18. The charges being considered by the Committee, as detailed in the Notice of Hearing, dated 16 June 2025, are as follows:

'That being a registered dentist:-

Patient A: Clinical

1. You failed to provide an adequate standard of care to Patient A between 7 May 2022 and 30 May 2022 including by/in relation to:

a) Not carrying out sufficient diagnostic assessments in that you did not conduct a cosmetic assessment of the upper anterior teeth.
b) Not carrying out sufficient treatment planning.
c) You provided a poor standard of treatment in that the composite bonding:

i. Was poorly contoured,
ii. Had a superficial layer poorly bonded to the underlying layer,
iii. Had an initial shade that was too dark,
iv. Had margins that were rough/uneven/overhanging,
v. Was poorly polished.

2. You failed to obtain informed consent for the treatment provided between 7 May 2022 and 30 May 2022 in that:

a) You did not provide Patient A with all treatment options.

b) *You did not discuss the cost of treatment at the second visit.*
c) *You filed UR3, UR4, UL3, UL4 without Patient A's consent.*

3. *You failed to respond adequately to Patient A's complaints about:*

a) *Being charged a further £1080 for treatment,*
b) *The remedial treatment.*

4. *You failed to treat Patient A with kindness and compassion, including by:*

a) *Shoving/pulling her head down on the bed,*
b) *Laughing in her face stating you* 'got what you asked for' *or words to that effect,*
c) *Leaving her alone whilst undergoing tooth whitening.*

5. *You provided dental treatment without adequate support.*

6. *Your actions in respect to 4c) and/or 5 put Patient A's safety at risk.*

Patient A: Dishonesty

7. *On 30 May 2022, you charged Patient A's account without her consent to do so.*

8. *Your conduct in respect of 7 was dishonest in that you knew you did not have Patient A's consent to charge her account.*

9. *On 15 November 2023 you provided, via your lawyers, the following documents to the GDC:*

a) *A patient questionnaire signed 05 May 2022 with a submission date of 17 May 2022*
b) *A patient questionnaire signed 07 May 2022 with a submission date of 07 May 2022*
c) *A patient questionnaire signed 17 May 2022 with a submission date of 17 May 2022*
d) *A patient questionnaire signed 05 July 2022 with a submission date of 07 May 2022*
e) *A consent form signed 17 May 2022 with a submission date of 17 May 2022*

f) Transcript of WhatsApp chat with Patient A
g) Patient treatment records dated 7 May
h) Patient treatment records dated 17 May

10. Your conduct in relation to 9a), 9b), 9c), 9d), 9e), above was:

a) Misleading,
b) Dishonest, in that the records purport to have been completed by Patient A but in fact were completed and/or edited by you.

11. Your conduct in relation to 9f) was dishonest in that the entry in Schedule 1 purporting to be from Patient A was in fact made by you.

12. Your conduct in respect of 9g) and 9h) was:

a) Misleading,
b) Dishonest, in that you have represented that the records relate to Patient A when they do not.

In the alternative to charge 12:

13. You failed to maintain an adequate standard of record keeping between 07 May 2022 and 30 May 2022 in that:

a) You recorded that Patient A's first appointment was on 7 May when in fact it was on 17 May,
b) You recorded that Patient A's second appointment was on 17 May when in fact it was on 30 May,
c) You did not record that you performed tooth whitening,
d) You recorded that you used the same shade at both appointments, when in fact you used different shades,
e) You did not record that you filed UR3, UR4, UL3 and UL4.

Patient B

14. You failed to provide an adequate standard of care to Patient B on 26 January 2022 in that:-

a) You did not undertake any or any adequate medical history from Patient B;

b) *You did not undertake any or any adequate assessment of Patient B's Covid-19 status;*
c) *You did not undertake any or any adequate occlusal assessment;*
d) *You provided a poor standard of composite bonding to Patient B's UR1 in that:-*

i. *The UR1 was bonded to the UL1,*
ii. *The composite bonding:-*
    a. *Was poorly contoured*
    b. *Was of a poor aesthetic result*
    c. *Had overhanging margins*
    d. *Left Patient B with bite problems*

e) *You provided a poor standard of composite bonding to Patient Bs UL1 in that:-*

i. *The UL1 was bonded to the UL2*

ii. *The composite bonding:-*
    a. *Was poorly contoured*
    b. *Was of a poor aesthetic result;*
    c. *Had overhanging margins*
    d. *Left Patient B with bite problems*

15. *On 29 March 2022 you sent an email to Patient B accusing her of acting with* "bad intent" *and threatening legal action for raising a complaint.*

16. *Your conduct in relation to 15 above:-*

a) *Unprofessional*
b) *Failed to respect Patient B's right to complain.*

CQC

17. *As practice principal you have failed to register the following locations with the Care Quality Commission:*

a) *Address A*
b) *Address C.*

And, that by reason of the facts alleged, your fitness to practise is impaired by reason of misconduct.'

Background

19. Ms Horri is a dentist, having joined the register in October 2020. The charges concern her treatment of two patients – Patient A (Charges 1 – 13) and Patient B (Charges 14 – 16). There is a further concern (Charge 17) regarding her failures as Practice Principal to register with the Care Quality Commission (CQC).

Patient A

20. In relation to Patient A, she corresponded with Ms Horri between 7 and 9 May 2022 via 'WhatsApp'. Ms Horri had recently provided Patient A's relative with dental treatment and Patient A made enquiries regarding composite bonding. She completed a consent form and paid a £50 deposit via a payment link sent to her by Ms Horri. On 16 May 2022, Patient A contacted Ms Horri via 'WhatsApp' to confirm their appointment arranged for 17 May 2022 and she was advised by Ms Horri to attend an address in London (Address A).

21. On 17 May 2022, Patient A travelled to London from her home in Merseyside. She attended a practice on the first floor of Address A. This was a practice called 'Company C'. Having waited in the waiting area, Ms Horri is said to have provided Patient A with an iPad, asked her to complete a form, and discussed the fact that Patient A was 20 weeks pregnant.

22. Patient A was taken to a consulting room and discussed the composite bonding treatment with Ms Horri who advised Patient A to have 'Zoom whitening' as part of the treatment and said this was included in the price for the bonding.

23. It is said that Ms Horri escorted Patient A out of Address A and down an alleyway to Address B. Patient A describes this as a *'far less pleasant building'* and that the room was not equipped for dental treatment. She described that there was just a bed of the type used for beauty treatments, and it was in this location that the whitening treatment took place. It is alleged that having applied whitening product to Patient A's teeth and placed a machine by her, she was then left by herself for around one hour. Patient A says she felt scared during this time.

24. Patient A described that when Ms Horri returned, she escorted Patient A back to Address A. However, instead of going back to Company C, they went to a room in

another part of the building. It is said that Patient A sat back in a dental chair but prior to the treatment starting, she sat up and asked why they were not in Company C. Patient A alleged that Ms Horri forcefully pulled her back into the chair, stating they were *'on the dental clinic'* and Patient A described being scared by this interaction.

25. It is alleged that when the bonding was applied, there was no dental nurse present. After the bonding was applied, Patient A described that she informed Ms Horri that she could feel some material stuck to the back of her teeth at which Ms Horri is said to have laughed and *said, 'she'd got what she asked for'*, before removing some material with a scalpel.

26. The following day, on 18 May 2022, Patient A noticed some issues with her teeth, and she raised these in 'WhatsApp' messages with Ms Horri who stated that she could return for the issues to be fixed, and that it would be done so free of charge.

27. Patient A returned to London on 30 May 2022 for the remedial treatment and attended Company C at Address A. Patient A said that she was taken by Ms Horri back to the room where she had had the initial composite bonding treatment. Ms Horri applied more bonding, allegedly with no dental nurse present. Patient A stated that her gums were cut in the process of this treatment.

28. According to Patient A, on 31 May 2022 £1080 was deducted from her bank account with the reference *'SUMUP Elena'.* Patient A stated that she did not consent to the payment, having been told via 'WhatsApp' messages and verbally that there was no charge for the further treatment. It is the GDC's case that Ms Horri was dishonest in taking this payment as she knew that Patient A did not consent to the payment.

29. Patient A stated that she continued to experience issues with the treatment she had received from Ms Horri. On 1 August 2022, Patient A attended a local dental surgery who advised that the bonding was overhanging her gums and needed to be removed. On 2 August 2022, Patient A relayed this information to Ms Horri who offered an appointment on 30 September 2022. Patient A declined the appointment and asked for her £1080 back. The GDC alleges that Ms Horri failed to respond adequately to Patient A's complaint about the £1080 or the remedial treatment.

30. Having still not received a refund by 10 December 2022, Patient A returned to London with the intention of confronting Ms Horri, but this did not happen as upon arrival at Address A, the receptionist is said to have told Patient A that Ms Horri had *'vanished'* and was *'nowhere to be seen'.*

31. Patient A provided the GDC with screenshots of the 'WhatsApp' messages exchanged with Ms Horri regarding the refund. A version of those messages has also been

provided by Ms Horri (via her legal representatives at the time), albeit in a text file format. A message timed at 11:12, containing abusive language, is not in the screenshots provided by Patient A. Patient A denies sending this message stating that she would never use the language contained within the message. It is the GDC's case is that this message was inserted in the text file by Ms Horri and was done so with dishonest intent.

32. Ms Horri, via those representing her at the time, provided patient questionnaire/consent forms in response to the GDC's inquiries about Patient A's case and they purport to have been completed by Patient A. It is the GDC's case that these documents have been completed and/or edited by Ms Horri, and that this has been done with dishonest intent.

33. Ms Horri, again via those acting for her at the time, provided screenshots of typed notes, dated 7 May and 17 May 2022, which purport to relate to Patient A. It was said on her behalf that these were created contemporaneously from paper records, albeit the paper records have been lost, and Ms Horri only has access to screenshots rather than the original electronic files. It is the GDC's primary case that these documents do not relate to Patient A at all, and that Ms Horri's conduct in putting them forward as such is misleading and dishonest. In the alternative, the GDC submitted that they amount to a failure to maintain an adequate standard of record keeping, the reasons for which being set out in the sub particulars of the charge.

34. In her 'Rule 4' observations to the GDC regarding the allegations, provided by Ms Horri's legal representatives at the time, she disputed Patient A's account, alleging that Patient A is not a truthful witness.

Patient B

35. In relation to Patient B, she had her front teeth composite bonded by Ms Horri at the practice at Address C in London on 26 January 2022 and was paid for by a 'Wowcher' voucher. Following her treatment, Patient B contacted another dental practice as she was unhappy with the result, and she was given an emergency appointment the next day.

36. On 27 January 2022 she attended the other dental practice. On examination, that dentist noted that there was a thick layer of composite on the buccal and incisal edge on UR1, UL1, and that UR1, UL1, UL2 were bonded together. As such, it was not possible to floss the area clean. There were overhanging margins at the gumline, and the composite was high in the bite. It was noted that aesthetically it did not match the adjacent teeth and the composite was removed.

37. Later that day, Patient B contacted Ms Horri by 'WhatsApp' explaining that she was unhappy with the treatment and requesting a refund. Ms Horri offered her an appointment, but this was declined. Patient B requested a refund only. Ms Horri asked for proof the visit to the local dental practice, and this was provided by Patient B.

38. The 'WhatsApp' messages indicate that on 31 January 2022 Patient B chased Ms Horri for a refund and was told it had been authorised but would take three to five business days. Patient B chased Ms Horri again on 4 February 2022.

39. On 9 February 2022, Patient B contacted 'Wowcher' complaining that she had not received a refund from Ms Horri. She stated that she had become concerned as to whether Ms Horri was in fact registered with the GDC.

40. On 29 March 2022, Ms Horri sent Patient B an email accusing Patient B of acting with *'bad intent'* and threatening legal action for raising a complaint. The GDC alleges that Ms Horri's conduct in doing so was unprofessional and failed to respect the patient's right to complain.

41. In her 'Rule 4' observations to the GDC regarding the allegations provided by Ms Horri's legal representatives at the time, the allegation that Ms Horri had provided a poor standard of treatment, including composite bonding, was admitted. Ms Horri suggested that Patient B had asked for her UR1, UL1, UL2 to be bonded together, and had only been done by Ms Horri after she had explained it was against clinical advice.

42. The GDC alleges that Ms Horri failed to respond adequately to Patient B's complaint about the dental treatment in that she threatened legal action against Patient B for raising a complaint and failed to communicate with Patient B in a professional/appropriate manner.

Care Quality Commission (CQC)

43. As part of the GDC's investigations, inquiries were made about whether Ms Horri was registered with the CQC. Witness 1, an employee of the CQC, confirmed in her statement that between January 2021 and December 2023, Ms Horri was not registered with the CQC to provide dental services at Address A, Address B, or Address C.

44. Witness 2, an employee of the GDC, provided a copy of Ms Horri's completed *'Working Arrangements and Indemnity Insurance'* form, in which Ms Horri provided Address B and Address C as the locations of her current places of work and described herself as practice principal in respect of each address.

45. In her 'Rule 4' observations in respect of Patient B, Ms Horri's previous legal representatives stated that between October 2021 and March 2022, she was carrying out *'exclusive private treatment… involving mainly aesthetic dentistry'* at Address C. This period covers 26 January 2022 when Patient B had her treatment.

46. Dentist A has a practice at Address C and stated that between 20 September 2021 and 18 March 2022, she rented a room to Ms Horri. A condition of the tenancy agreement was that the tenant (Ms Horri) was responsible for her own CQC registration. Dentist A stated that Ms Horri was aware of this. She also confirmed that Ms Horri used the room at Address C on 26 January 2022.

47. Dentist B was a partner at Company C until June 2024. A clinical room was rented to Ms Horri in 2022, and Dentist B's understanding was that Ms Horri mainly carried out composite bonding work in the room. He did not discuss directly the issue of CQC registration with Ms Horri but is able to confirm that Ms Horri did not work for Company C.

48. Dentist C was also a partner at Company C and he agreed that Ms Horri was responsible for organising her own CQC registration for her work at Address A.

49. In her 'Rule 4' observations in respect of Patient A, Ms Horri stated that Address B was never registered with the CQC as she carried out no dental services there, *'only whitening'*. She does not comment on any other locations.

Evidence

50. The Committee had regard to a number of documents included within the GDC hearing bundle, referred to as Exhibit 1. This bundle included, but was not limited to, the following documents:

- Written witness statements of the following:
  - Patient A
  - Witness 1
  - Witness 2
  - Dentist A
  - Dentist B
  - Dentist C
- Expert reports of the following expert witnesses:

  - Dr Lucy Nichols
  - Dr Nikolai Stankiewicz

- Ms Horri's 'Rule 4' observations
- Patient A's dental records
- Patient B's dental records

51. The Committee also heard oral evidence from the following witnesses:

- Patient A
- Dentist A
- Dentist B
- Dentist C
- Witness 1
- Dr Nichols
- Dr Stankiewicz

Submissions

52. Ms Woolfson, on behalf of the GDC, provided written submissions which were exhibited by the Committee. To assist the Committee, Ms Woolfson provided an oral summary of her written submissions and highlighted a number of areas where additional detail was provided.

53. The Committee was not provided with any written submissions given Ms Horri's absence, but it bore in mind the 'Rule 4' observations provided by Ms Horri's previous legal representatives, which included a number of criticisms and allegations made by Ms Horri against Patient A. Ms Woolfson submitted that these are unfounded. She submitted that even if the Committee did not accept the GDC's case, which is that the offensive message in Schedule 1 emanated from Ms Horri, it does not automatically follow that Patient A sent the message. Ms Woolfson stated that the request made by Patient A to Ms Horri to pay for her train ticket to London is not inappropriate. Further, she submitted that none of the photos shared by Patient A can be said to be sexually suggestive and there is no reason to think that she sent other photos which were inappropriate.

54. Ms Woolfson submitted that there is no evidence that Patient A has *'intentionally lied and deceiving'* [sic], as per Ms Horri's comments in the 'Rule 4' observations. She submitted that Ms Horri's reaction to Patient A's complaint to the GDC bears some

similarity to her reaction to Patient B's complaint to 'Wowcher', which those representing Ms Horri accepted (on her instructions) was inappropriate.

55. Ms Woolfson reminded the Committee that Ms Horri has made no further comment on the case since the 'Rule 4' observations and that she has not responded to the charges or provided any other representations. Ms Horri was warned on 7 February 2025, 15 May 2025, and 8 July 2025 of the risk that the Committee could draw adverse inferences from her absence.

Finding of facts

Committee's findings

56. The Committee considered all the evidence presented to it. The Committee was mindful that the best evidence on which to base fact finding will always be objective matters shown by contemporaneous documentation. In this case there was a lack of reliable documentation. Additionally, some of the expert evidence was based on Patient A's clinical notes which the Committee have subsequently concluded did not relate to Patient A. It noted that the only information before it from Ms Horri were her Rule 4 observations. In considering the weight to attach to them, the Committee bore in mind that they were not in response to the finalised charges and their contents were untested by questioning. The Committee also took account of the closing submissions made by Ms Woolfson, on behalf of the GDC. The Committee accepted the advice of the Legal Adviser who referred the Committee to relevant case law to assist in its decision-making. It considered each head of charge 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 facts are proved on the balance of probabilities.

Patient A's clinical notes

57. The Committee first considered whether the clinical notes submitted by Ms Horri via Clyde & Co, pertaining to be for Patient A, are indeed Patient A's notes.

58. The Committee considered the clinical notes submitted by Ms Horri. These were dated 7 May 2022 and 17 May 2022. There were no notes submitted for 30 May 2022. It also considered the other documentary evidence, including the 'WhatsApp' messages. The Committee was satisfied that Patient A attended an appointment with Ms Horri on 17 May 2022 and 30 May 2022, despite the absence of clinical notes for the latter date. Patient A did not attend an appointment on 7 May 2022.

59. The Committee noted the following discrepancies between the information recorded in the notes dated 7 May 2022 and the evidence provided to it about Patient A's initial appointment:

- mentions lower tooth whitening only. Patient A confirmed that she underwent 'Zoom' whitening treatment on upper and lower teeth;
- a basic periodontal examination (BPE), which is charted and recorded upon the physical examination of a patient's mouth, has been recorded. Patient A was not present on 7 May 2022 for such an examination to have taken place;
- notes record temporomandibular joint disorder (TMD) discussion and examination as *'TMJ nil'.* Patient A stated that she suffers from TMD but that this was not discussed with Ms Horri at her initial appointment.

60. The Committee did note some similarities in the notes provided for 7 May 2022 with the information Patient A asserted was obtained from her at her initial appointment on 17 May 2022, including a discussion regarding composite bonding on upper teeth, tooth whitening treatment and equipment used for these procedures. However, the Committee bore in mind that Ms Horri provided cosmetic and aesthetic dentistry treatment, and it was likely that many if not all of her patients would have had similar consultations and therefore there was a high likelihood of there being similarities in all patient clinical notes.

61. In addition, the Committee took into account the representations from Clyde & Co, which state:

> *'I am instructed to relay that contemporaneous paper records were made for both 7 May and 17 May 2022 appointments in respect of this patient but, much to the registrant's frustration and embarrassment, she can no longer find these records and they are presumed lost. I am instructed to confirm these were simple blank paper records. Fortunately, the registrant was using a dual system where she was also making notes on her notepad/tablet (intended only as a draft, mainly to check at the end of the day to ensure the notes were correctly assigned to each patient and in case of any loss to her paper records) in respect of which she took a screenshot and we provide these for the GDC's attention. Fortunately, these screenshots of the notes, confirmed in the file properties as being taken on the day of each appointment and subsequently copied over from a device which the registrant is no longer in possession of, are sufficiently detailed so to enable a third party to understand the assessments undertaken together with treatment provided.'*

62. The Committee considered the screenshots of the clinical notes submitted by Ms Horri via Clyde & Co who had specifically referred to the properties of the screenshot. The *'Origins'* box records *'Date taken'* as *'07/05/2022 17:53'*. Whilst the Committee had no expert evidence on this, it noted the screenshot of the clinical notes submitted by Ms Horri (purporting to be from Patient A's first appointment on 7 May 2022). However, it was the Committee's conclusion that whilst Ms Horri may have seen a patient on 7 May 2022, it was not Patient A as it accepted Patient A's account that she was not in London that day. The Committee accepted that Patient A's first appointment was on 17 May 2022, some ten days after the screenshot was taken.

63. On the balance of probabilities, the Committee concluded that the 7 May 2022 notes did not belong to Patient A and likely relate to another patient.

64. It was accepted by Ms Horri that she saw Patient A for an appointment on 17 May 2022. However, the Committee noted that the information contained within the clinical notes provided for this date did not correspond with the account given by Patient A for her first appointment. The clinical notes submitted for 17 May 2022 did have some similarities with the account given regarding the second appointment with Patient A on 30 May 2022, including:

- reference to the patient desiring a *'whiter shade'*
- still wanting to have a natural look
- details recorded for equipment used in line with the treatment that is said to have taken place at Patient A's second appointment.

65. The Committee also noted that the screenshot properties provided for 17 May 2022 appointment showed the *'Origins'* box records the *'Date taken'* as *'17/05/2022 21:04'.* The Committee already accepted that Patient A's second remedial appointment was on 30 May 2022, some two weeks after the screenshot was taken.

66. On the balance of probabilities, the Committee concluded that the 17 May 2022 notes also did not belong to Patient A and likely relate to another patient.

Charge 1

1. *You failed to provide an adequate standard of care to Patient A between 7 May 2022 and 30 May 2022 including by/in relation to:*

a) *Not carrying out sufficient diagnostic assessments in that you did not conduct a cosmetic assessment of the upper anterior teeth.*
PROVED

b) *Not carrying out sufficient treatment planning.*
PROVED

c) *You provided a poor standard of treatment in that the composite bonding:*

i. *Was poorly contoured,* ***NOT PROVED***
ii. *Had a superficial layer poorly bonded to the underlying layer,* ***PROVED***
iii. *Had an initial shade that was too dark,* ***NOT PROVED***
iv. *Had margins that were rough/uneven/overhanging,* ***PROVED***
v. *Was poorly polished.* ***NOT PROVED***

67. In coming to its decision on this allegation, the Committee had regard to the written statement and oral evidence of Patient A, the expert report of Dr Nichols, and Ms Horri's 'Rule 4' observations document provided by her previous legal representatives at Clyde & Co. It also bore in mind its findings that the clinical records provided do not pertain to Patient A.

Charge 1a)

68. In relation to Charge 1a), the Committee bore in mind that Dr Nichols was provided with the 7 May and 17 May 2022 notes in coming to her conclusion. Whilst the Committee has determined that the notes submitted by Ms Horri do not pertain to Patient A, it bore in mind her professional assessment of the information contained within it.

69. In her expert report, Dr Nichols states:

> *'… the diagnostic assessment required in this case was a cosmetic assessment of the upper anterior teeth. The form filled by the Patient indicates that she was wanted* [sic] *whiter teeth ... For example,* [a diagnosis of any specific cosmetic problem with the teeth] *... could include noting if any specific teeth were positioning more labially or palatally, were extruded or intruded compared to adjacent teeth, or were rotated, as well as tooth shape issues such as wear, chipping, flared shape, too rounded, or any other shape issue. In my opinion,* [failing to make such a diagnosis

would be] *far below the expected standard, because with such an assessment of what cosmetic issues were present, there was no logical indication to carry out the treatment provided, which was a treatment which would risk irreversible damage to the teeth.'*

70. The Committee accepted the advice of Dr Nichols in relation to the assessment that would be required before undertaking composite bonding treatment and the reasons for doing so. In the absence of any clinical notes, the Committee carefully considered the evidence of Patient A to consider whether or not such an assessment was undertaken.

71. Patient A clearly recalled that she discussed her requests for treatment with Ms Horri via 'WhatsApp' and stated, *'Prior to my appointment with [Ms Horri], I never asked for teeth whitening as I already knew that I had white teeth, and I was content with the colour of my teeth.'* However, she confirmed that she completed an online tooth whitening consent form sent to her via an online link on 7 May 2022, prior to her appointment with Ms Horri on 17 May 2022, without Ms Horri having undertaken any physical assessment. In her written statement, Patient A recalled,

> *'I completed the new patient consent form as I was told by [Ms Horri] to complete it. It was never my intention to complete a tooth whitening form as I know, from the outset, that I do not need tooth whitening as my teeth were already white. My understanding was, the £50 deposit was for the composite bonding, not for teeth whitening, and to secure my appointment with [Ms Horri]. I note that I was never examined by [Ms Horri] before my appointment with her on 17 May 2022 and prior to my first appointment with [Ms Horri] on 17 May 2022.'*

72. In relation to any physical assessment undertaken, Patient A recalled that Ms Horri did take a look inside her mouth using what she described as a *"probe",* but she was unable to recall whether anything was written down and that nothing was discussed with Patient A as a result of the examination.

73. Therefore, the Committee has determined that Ms Horri failed to provide an adequate standard of care by not carrying out sufficient diagnostic assessments, including a cosmetic assessment, of the upper anterior teeth.

74. Accordingly, the Committee found **Charge 1a) proved.**

Charge 1b)

75. In relation to Charge 1b), the Committee noted Dr Nichols' evidence in that:

'*Without an appropriate diagnostic assessment of the cosmetic issues which were concerning the Patient, an appropriate treatment plan could not be made... Given that the Patient wrote on her form that she wanted whiter brighter teeth, in my opinion, the most appropriate treatment would have been tooth whitening. If during the diagnostic assessment and discussion with the Patient it became apparent that the Patient also wanted to alter the shape of the teeth, it is likely that this could have been achieved with composite edge bonding, and possibly a composite veneer just on UR2 which was slightly in-standing… I note that the Whats App messages suggest the Patient was aware that the composite would cover the whole teeth. However, the Registrant advised the Patient of this before carrying out an in-person examination. In my opinion, it would be the responsibility of the Registrant to advise her on the most appropriate treatment having carried out an inperson examination. Whilst 8 composite veneers would have been one option for the, in my opinion, the treatment planning was far below the expected standard for the reasons above.*'
[sic]

76. The Committee acknowledged that Patient A was not provided with a written treatment plan for the procedure undertaken on 17 May 2022. It bore in mind that, when undertaking treatment planning for a patient, a number of factors are considered and discussed with the patient before the commencement of treatment.

77. In this case, the Committee noted Patient A's evidence that Ms Horri did advise her to undergo tooth whitening treatment and to have composite veneers having been provided with photographs of Patient A's teeth. This was also provided in the screenshots of the 'WhatsApp' exchanges, prior to Patient A attending her initial appointment with Ms Horri. However, there is no evidence before the Committee that Ms Horri undertook any treatment planning at Patient A's initial appointment, beyond confirming the treatment she had suggested before examining Patient A as a result of the photographs sent in advance of the initial appointment. The Committee concluded that, even if this were to be considered a plan for treatment, it was insufficient in the circumstances.

78. Therefore, the Committee has determined that Ms Horri failed to provide an adequate standard of care by not carrying out sufficient treatment planning.

79. Accordingly, the Committee found **Charge 1b) proved.**

Charge 1c)

80. In relation to Charge 1c), the Committee noted Dr Nichols' expert report and the photographs provided by Patient A.

Charge 1c)i.

81. When considering the contouring (Charge 1c)i.) between 7 May and 30 May 2022, the Committee had regard to the expert opinion of Dr Nichols. It noted that she asserted that there was *'poor contour of all the veneers'.* However, the Committee noted that she was considering images that were taken 18 months after the treatment. Dr Nichols did not provide any specific and objective parameters to assess the quality of the contouring and, in the Committee's opinion, they considered the contouring to be of an acceptable standard.

82. Further, Dr Nichols did not opine in relation to contouring when considering in her report the 'WhatsApp' photographs sent by Patient A which were taken one day after the initial treatment.

83. Therefore, the Committee found that the GDC had not discharged its burden of proof that Ms Horri had failed to provide a poor standard of treatment in that the composite bonding was poorly contoured.

84. Accordingly, the Committee found **Charge 1c)i. NOT proved.**

Charge 1c)ii.

85. Dr Nichols opined that the later photographs of Patient A's teeth, taken some three months after the initial treatment, show a superficial layer of lighter shade composite poorly bonded to the underlying layer and chipping off. She stated:

> *'…it is clear that a lighter shade was layered over the original shade at the second appointment. Adding another layer on top to correct colour issues is inappropriate as it will cause the teeth to be too bulky, and there is a risk that the previously cured composite will not adhere ideally to the new layer of composite. This can lead to the upper layer chipping of the lower layer as occurred.'*

86. The Committee accepted Dr Nichols' evidence in this regard. It also noted that in the 'WhatsApp' exchanges between Ms Horri and Patient A on 2 August 2022, Patient A stated that, having visited the hygienist, she had been advised that the composite had *'…chipped a lot!'*

87. The Committee acknowledged the chipping of the composite on the distal edge of the UR2 and that, only three months after the treatment was completed, this chipping had occurred very quickly.

88. Therefore, the Committee was satisfied that Ms Horri failed to provide an adequate standard of treatment in that Patient A's composite bonding had a superficial layer poorly bonded to the underlying layer.

89. Accordingly, the Committee found **Charge 1c)ii. proved.**

Charge 1c)iii.

90. In coming to its decision, the Committee noted that Dr Nichols did not offer an opinion to substantiate this charge. Further, and in any event, it had regard to the photograph taken after the initial treatment on 17 May 2022. In comparing the colour match, the Committee considered that the colour of the composite was, subjectively, a close match to Patient A's teeth.

91. In this regard, and in the absence of a treatment plan stating what shade was planned to be used and how this decision had been made, the Committee was unable to determine that the initial shade was 'too dark', as alleged.

92. Therefore, the Committee found that the GDC had not discharged its burden of proof that Ms Horri provided a poor standard of treatment in that the composite bonding had an initial shade that was too dark.

93. Accordingly, the Committee found **Charge 1c)iii NOT proved.**

Charge 1c)iv.

94. In considering whether the margins were rough, uneven, and/or overhanging, the Committee had regard to Dr Nichols' expert report, in which she opined:

> *'The poor margins in particular can be seen in some photos to be causing significant gingival inflammation and bleeding… See the photo of August 2022 below taken 3 months after the treatment. This photo in particular shows the marginal gingivitis, seen as the redness at the gumline, caused by the poor margins of the veneers. The … margins look rough, uneven and/or overhanging.'*

95. In the 'WhatsApp' exchanges on 2 August 2022, Patient A stated:

> *'I went to see my dentist yesterday and I saw the hygienist… And they said that there are lots of problems with my composites and to contact you as they need fixing…*
>
> *The composite had been fitted too far up and it is overlapping my gum so every time I brush my teeth they are pouring with blood but only where the composite is.*
>
> *And they said it is definitely not gum disease it's the composite…'* [sic]

96. The Committee also had regard to the photographs provided by Patient A. One photograph shows redness, swelling and blood at the gumline on at least UR1, UR2, UR3, UL1, UL2 and UL3. In another photograph, when Patient A has cleaned her teeth, there is fresh blood coming from the gums on the same teeth.

97. The Committee was satisfied that, as a result of the overhang following the remedial appointment on 30 May 2022 Patient A was unable to keep her mouth clean and that damaged had been caused. It was clear from the images provided from August 2022 that the edges of the composite were rough, uneven, and overhanging and it was unlikely that such damage would have been caused in such a short time had the remedial treatment not been of a poor standard.

98. Therefore, the Committee was satisfied that Ms Horri had provided a poor standard of treatment in that the composite bonding had margins that were rough and uneven and overhanging.

99. Accordingly, the Committee found **Charge 1c)iv. proved.**

Charge 1c)v.

100. In coming to its decision on this charge, the Committee had regard to the expert report of Dr Nichols. Dr Nichols stated that, in her opinion, the photographs from August 2022, taken three months after the treatment shows that, *'The veneers are all very flat, dull and poorly polished.'* Dr Nichols also stated that the photographs submitted by Patient A's subsequent treating dentist from January 2023, some 18 months after the remedial treatment appointment on 30 May 2022, were also "*dull, poorly polished and flat*".

101. The Committee carefully considered the other photographic evidence provided to it. The Committee concluded that, when viewing the two photographs and the video still sent to Ms Horri by Patient A on 18 May 2022, Patient A's teeth were sufficiently polished. These are the only images of Patient A's teeth that can be considered contemporaneous as they were sent the day after the initial treatment.

102. Patient A provided further photographs to Ms Horri in August 2022, in which the teeth also appeared to the Committee to have a shine and did not look flat and dull, as described by Dr Nichols.

103. A further photograph was submitted by Ms Horri as part of her 'Rule 4 observations', which appears to show Patient A's teeth before and after treatment. The Committee was satisfied that this photograph was highly likely to have been taken by Ms Horri for the 17 May 2022 appointment as there are buccal retractors in situ and the person in the photograph is seen to be wearing the same jacket Patient A is known to have worn on that date. This photograph shows a split-screen on two images, one seemingly taken after the composite bonding treatment and the shape and size of the teeth differs in each image. In the image, assumed to be taken after the treatment, the teeth appear to be shiny and do not look like they have been poorly polished.

104. In light of the absence of any definitive evidence of Patient A's teeth immediately after the remedial treatment on 30 May 2022, the Committee determined that the GDC has not discharged its burden of proof that the composite was poorly polished between 7 May and 30 May 2022.

105. Accordingly, the Committee found **Charge 1c)v. NOT proved.**

Charge 2

2. *You failed to obtain informed consent for the treatment provided between 7 May 2022 and 30 May 2022 in that:*

   a) *You did not provide Patient A with all treatment options.* ***NOT PROVED***
   b) *You did not discuss the cost of treatment at the second visit.* ***NOT PROVED***
   c) *You filed UR3, UR4, UL3, UL4 without Patient A's consent.* ***PROVED***

106. The Committee noted that this was a case where it did not have any clinical records before it relating to Patient A. The only documentation that the Committee had before it were consent forms. The GDC relied upon the evidence and recollection of Patient A. The Committee had to make an assessment as to the reliability of Patient A's account. It reminded itself that assessing demeanour was the least helpful judicial tool for determining this. The Committee took into account the written and oral evidence of Patient A. It noted that there were a number of inconsistencies and contradictions in Patient A's evidence that undermined in the Committee's judgement, her reliability as an accurate historian. For example, Patient A was inconsistent in relation to discussions about tooth whitening and having signed consent forms. In addition, Patient A gave inconsistent accounts as to when the alleged bad behaviour (set out in charges 4a) and 4b) took place. Patient A gave oral evidence that she never spoke to Ms Horri outside of the dental appointments and all communications with Ms Horri were via WhatsApp . However, in her witness statement, Patient A said that she telephoned Ms Horri. Further, the Committee received no plausible explanation from Patient A as to why various significant complaints against Ms Horri were not raised initially and only arose later.

107. The Committee noted that Patient A maintained that treatment options were not discussed, whereas Ms Horri in her Rule 4 observation asserted that all options were discussed. The Committee had to make an assessment of Patient A's reliability and had regard to the consent forms and WhatsApp messages which were the only contemporaneous documentation before it.

108. The Committee acknowledged that there is evidence of discussions regarding treatment between Patient A and Ms Horri in the screen shots of the 'WhatsApp' exchanges. Further, the Committee has seen two consent forms, one dated 7 May and one dated 17 May 2022. These are not particularised but do record that treatment alternatives were discussed.

109. Having regard to all the information before it, and its assessment of the reliability of Patient A's recollection, the Committee was not persuaded that the GDC has discharged the burden of proof such that it could conclude, on the balance of probabilities, that treatment options were not provided. Accordingly, the Committee found **Charge 2a) not proved.**

Charge 2b)

110. This charge relates to whether or not Ms Horri discussed the cost of treatment at the second visit (30 May 2022). The GDC's case is that Ms Horri did not.

111. There was evidence before the Committee from Patient A and from Ms Horri in her Rule 4 observations that there was a discussion about what further remedial work was proposed and whether it was free or not. It appears there is a dispute between Patient A and Ms Horri as to whether the addition of a new composite would be charged or not.

112. On all the information before it, for the reasons set out above, the Committee was not satisfied that it could rely on Patient A's version as more likely than not to be correct. Accordingly, the GDC had not proved to the requisite standard that there was a failure to discuss the cost of treatment at this second visit.

113. Accordingly, the Committee found **Charge 2b) NOT proved.**

Charge 2c)

114. Patient A informed the Committee that she clearly remembered informing Ms Horri that she did not want her teeth to be filed and that she wanted the composite bonding to the teeth edges so, should she wished to remove the composite in the future, she could return her teeth to their natural state. Patient A stated:

> *'I recall this was discussed with [Ms Horri] when I was laying on the dental chair just before the composite bonding started on the first appointment, 17 May 2022. [Ms Horri] assured me she would not file down/level off my teeth. I recall discussing with* [my own dentist] *before he started redoing [Ms Horri's] composite bonding and that I didn't think [Ms Horri] had filed down my teeth. However, I was wrong and* [my own dentist] *confirmed that filing and levelling off had been done to at least both of my upper canine teeth. I was not aware of this being done until I clearly saw that it had been during the treatment with* [my own dentist].

115. It was also evident to the Committee in the photograph from January 2024 that there had been some filing of Patient A's teeth.

116. The Committee noted that there was a consent form which Patient A completed prior to the appointment with Ms Horri. One clause of the 'composite bonding' consent form, dated 'May 7, 2022', stated:

> *'4. Possible Irreversible damage to enamel ,filing teeth or leveling down teeth depends on circumstances.'*
> [sic]

117. Despite the signature on the consent form, the Committee found that Patient A's recollection to this specific issue of not wanting her teeth to be filed was more likely than not to be correct. Her recollection was detailed. Unlike her evidence in other areas, Patient A maintained this position without inconsistencies. She stated that she specifically told Ms Horri this after the signing of the consent form and the Committee noted that this clause was in small print in any event. Therefore, despite the Committee's concerns as to Patient A's reliability in other areas, it was satisfied that her recollection of this charge was accurate.

118. Accordingly, the Committee found **Charge 2c) proved.**

Charge 3

3. You failed to respond adequately to Patient A's complaints about:

a) Being charged a further £1080 for treatment, ***NOT PROVED***
b) The remedial treatment. ***NOT PROVED***

119. The Committee noted that Patient A contacted Ms Horri on 18 May 2022 at 07:47 regarding concerns she had about the treatment from the previous day. She detailed a number of issues including that there was composite on the back of her teeth, that the composite material had discoloured and was unhappy about the shaping and finish.

Charge 3a)

120. This charge relates to whether the GDC has proved that Ms Horri failed to respond adequately to Patient A's complaint about being charged a further £1080 for treatment.

121. The Committee was satisfied that following the duty set out at Standard 5.3, there is an obligation upon Ms Horri to have responded to this complaint.

122. A remedial appointment was arranged and attended by Patient A on 30 May 2022. Patient A stated that she was subsequently charged £1080 for the remedial treatment undertaken on 30 May 2022 without her consent. When this was raised with Ms Horri on or around 8 October 2022, she responded on 17 October 2022 at 13:06, stating that:

'You had a treatment and you asked for Whiter composite and new material was used for you and previous repair was free of charge but new composite was on payment and that's why you paid for it' .
[sic]

123. Ms Horri confirmed in her 'Rule 4 observations' that Patient A was charged for what she considered to be additional treatment on 30 May 2022, as follows:

> *'[Patient A] was presented to the practice 3 times charged 2 times for the treatments offered free repair on chipped and explained new set of bonding cost her similar as it is the new treatment and is not considered minor repair anymore but her desire to change the shade completely.'*

124. The Committee was satisfied that Ms Horri responded to the October 2022 complaint in a timely fashion and provided a written explanation via her 'WhatsApp' messages with Patient A. This was to the effect that the remedial treatment was covered free of charge but that the £1080 was for the new composite bonding.

125. The Committee was satisfied that this was an adequate response to the complaint and therefore the Committee did not find that Mr Horri failed to respond adequately to Patient A's complaints about being charged a further £1080 for treatment.

126. Accordingly, the Committee found **Charge 3a) NOT proved.**

Charge 3b)

127. The GDC's case was that Ms Horri failed to respond adequately to Patient A's complaint regarding the remedial treatment that was undertaken on 30 May 2022.

128. The Committee had regard to the following timeline of the complaint in its consideration of this charge:

- 2 August 2022: Patient A makes complaint
- 2 August 2022: Ms Horri responded asking what the problems were and for Patient A to send dental records
- 26 August 2022: Patient A chases Ms Horri for a response
- 31 August 2022: Ms Horri responds to Patient A's complaint
- 1 September 2022: Offers 30 September 2022 for remedial treatment

129. The Committee noted that Ms Horri made an immediate response to the initial complaint on 2 August 2022 and asked for the subsequent treating records to be submitted. Patient A in her witness statement confirmed that she did not send any dental records to Ms Horri. Patient A then chased Ms Horri for a response on 26

August 2022. On 31 August 2022 Ms Horri responds to Patient A's complaint and on 1 September 2022 offered an appointment on 30 September 2022 for remedial treatment.

130. In all the circumstances, the Committee was not persuaded that either the period of time that elapsed or the content of Ms Horri's responses were such that it could conclude that Ms Horri had failed to respond adequately.

131. Therefore, the Committee found **Charge 3b) NOT proved.**

Charge 4

4. You failed to treat Patient A with kindness and compassion, including by:

a) Shoving/pulling her head down on the bed, ***NOT PROVED***
b) Laughing in her face stating you 'got what you asked for' *or words to that effect,* ***NOT PROVED***
c) Leaving her alone whilst undergoing tooth whitening. ***PROVED***

132. In its consideration of Charge 4, the Committee bore in mind Standard 1.2, as follows:

Standard 1.2: You must treat every patient with dignity and respect at all times

1.2.3 You must treat patients with kindness and compassion.

Charges 4a) and 4b)

133. The Committee had concerns in relation to Patient A's evidence regarding Charges 4a) and 4b).

134. Firstly, in her initial contact with the GDC via an online form, *'Original Webform Complaint'* dated 22 August 2023, Patient A did not mention being shoved or having her head pulled down at all.

135. Secondly, Patient A's contemporaneous 'WhatsApp' messages broadly expressed satisfaction with the treatment and did not refer to any alleged shoving or comments

made. The message dated 18 May 2022 stated: *'…I Jsut* [sic] *don't feel like they are very white [crying face emoji] but other than that I love them!!! X'.*

136. Further, in Patient A's 'WhatsApp' message with Ms Horri dated 1 September 2022, she referred to Ms Horri as *'a lovely person'*. Again, there was no mention of alleged shoving or comments made.

137. Patient A first mentioned 'the shoving incident' in an email to the GDC dated 14 February 2024 (some 22 months after the alleged incident). It appears Patient A never complained about this incident directly to Ms Horri. In her email dated 14 February 2024 Patient A stated:

> *'I told [Ms Horri] that I felt uncomfortable to which she shoved my head down onto the bed and began my treatment. After the veneers were applied she showed me and I told her there were a few issues I was not happy with and she laughed in my face and told me I 'got what I asked for'.'*

138. Ms Horri responded to the allegation that she had shoved and/or pulled Patient A's head in her 'Rule 4 observations', stating that:

> *'[Patient A] alleged I* "shoved her head" *during treatment, but did not report this to the police or stop the treatment. This is inconsistent with such an act of force and appears to be a false allegation.'*

139. Therefore, in light of the matters set out above, and the discrepancies and inconsistencies in Patient A's account, the Committee was not satisfied that it could rely on Patient A's account. Accordingly, it found that the GDC had not discharged its burden of proof that Ms Horri failed to treat Patient A with kindness and compassion by shoving/pulling her head down on the bed and laughing in her face stating you *'got what you asked for'* or words to that effect.

140. In addition, in relation to the allegation of 'laughing in her face and comments made (charge 4b) the Committee was concerned that Patient A gave three different timelines as to when this occurred (at the clinic at the first appointment on 17 May 2022; when she returned to Liverpool and at the clinic at the second appointment on 30 May 2022). Whilst the Committee recognise that a witness's recollection of events can be inconsistent and confused as to a timeline, and still credible, given the extent of the inconsistencies including her description of the alleged incident the Committee could not place weight on Patient A's account.

141. For these reasons, the Committee was not persuaded that the GDC had discharged its burden of proof that Ms Horri failed to treat Patient A with kindness and compassion by shoving/pulling her head down on the bed and laughing in her face stating you *'got what you asked for'* or words to that effect,

142. Accordingly, the Committee found **Charges 4a) and 4b) NOT proved.**

Charge 4c)

143. The Committee heard from Patient A that she was taken from Address A to Address B down an external alleyway and that she was left alone for the tooth whitening procedure.

144. Patient A recalled the following:

> *"[Ms Horri] was not with me throughout the treatment, and I was alone and scared. I cannot remember what she said to me before she left but she said something along the lines* of "wait here for an hour and I will be back". *She left me alone in a room, lying on the bed, by myself as soon as she had put the teeth whitening on my teeth.'*

145. The Committee acknowledged that the tooth whitening procedure would be approximately 60 minutes and that Patient A would therefore have been left alone in Address B for an extended period of time. The Committee took into account that Patient A was 20 weeks pregnant and would have been expected to lie on her back for the duration of the treatment with the whitening agent on her teeth and, presumably, a buccal retractor in her mouth.

146. There was no evidence before the Committee that Ms Horri arranged for someone else to check on Patient A's welfare during the course of the hour-long treatment whilst she was in a separate building.

147. The Committee accepted Dr Nichols' opinion that, if the Committee was minded to find that Patient A had been left alone during the tooth whitening treatment, this would amount to a failure on Ms Horri's part to treat Patient A with kindness and respect. '

148. Therefore, the Committee was satisfied that by leaving Patient A alone whilst undergoing tooth whitening treatment, Ms Horri had failed to treat Patient A with kindness and compassion.

149. Accordingly, the Committee found **Charge 4c) proved.**

Charge 5

5. You provided dental treatment without adequate support. ***PROVED***

150. The Committee had regard to Standard 6.2, as follows:

> ***Standard 6.2: You must be appropriately supported when treating patients***
>
> *6.2.2 You should* work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.*
>
> *The only circumstances in which this does not apply are when:*
>
> - *treating patients in an out of hours emergency,*
> - *providing treatment as part of a public health programme, or*
> - *there are exceptional circumstances.*
>
> *'Exceptional circumstances' are unavoidable circumstances which are not routine and could not have been foreseen. Absences due to leave or training are not exceptional circumstances.*
>
> * *'should' is used where the duty would not apply in all situations and where there are exceptional circumstances outside your control that could affect whether, or how, you can comply with the guidance. Should is also used when we are providing an explanation of how you will meet the overriding duty.*

151. Patient A gave evidence that she was treated by Ms Horri without anyone else present. The Committee noted that it was Dr Nichols' opinion that if Ms Horri was providing treatment without a dental nurse, this would constitute a breach of Standard 6.2.

152. The Committee considered whether the presence of other dental professionals in the same building discharged the obligation to have adequate support and was satisfied that for this treatment it did not.

153. The Committee accepted the opinion of Dr Nichols and was satisfied that Ms Horri should have been working with another appropriately trained member of the dental team when providing dental treatment.

154. Accordingly, the Committee found **Charge 5 proved.**

Charge 6

> 6. *Your actions in respect to 4c) and/or 5 put Patient A's safety at risk.*
> ***PROVED in respect of Charge 4c)***
> ***NOT PROVED in respect of Charge 5***

155. The Committee found that Ms Horri failed to treat Patient A with kindness and compassion by leaving her alone whilst undergoing tooth whitening (Charge 4c)) and provided dental treatment without adequate support (Charge 5).

156. The Committee considered that it was self-evident that there were risks of potential harm to a patient who was left alone during the course of hour-long treatment whilst undergoing tooth whitening treatment. The Committee noted the evidence of Dr Nichols who referred to Standard 6.2.6, as follows:

> ***Standard 6.2: You must be appropriately supported when treating patients***
>
> *6.2.6* *Medical emergencies can happen at any time. You must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient.*

157. In relation to Charge 4c), the Committee has already determined that the risk of medical emergency could not be discounted and that Patient A was left alone at Address B. The Committee bore in mind that Patient A would have been in a vulnerable position, lying on her back with a buccal retractor in place which would impeded on her ability to call for help or go to find it in an emergency. In addition, were Patient A to have fallen unconscious for example, there would have been no way of raising the alarm to get her emergency help.

158. Therefore, the Committee was satisfied that by leaving Patient A alone whilst undergoing tooth whitening in a separate building, Ms Horri put Patient A's safety at risk.

159. Accordingly, the Committee found **Charge 6 proved, in respect of Charge 4c).**

160. When considering Charge 5, the GDC's case was put to the Committee in respect of the composite bonding treatment which took place at Address A.

161. The Committee heard from Dentist B and Dentist C that at Address A there was an informal arrangement in place that should emergency assistance be required, someone from one of the surrounding practices in the same building would attend.

162. It considered that whilst Ms Horri was treating Patient A at Address A, there were appropriately trained dental staff available to assist her should an emergency arise whilst she was applying the composite bonding. Ms Horri herself would have been able to raise an alarm and request emergency assistance for a patient in this situation, unlike a patient who has been left alone for an extended period of time.

163. The Committee carefully considered that whilst the other dental professionals were not working alongside Ms Horri in the treatment of Patient A, the Committee accepted that the arrangement in place meant that the omission in Charge 5 did not put Patient A's safety at risk.

164. Therefore, the Committee found that Ms Horri had not put Patient A's safety at risk by providing dental treatment without adequate support because in the particular circumstances there were other dental professionals available on the same floor.

165. Accordingly, the Committee found **Charge 6, in respect of Charge 5, not proved.**

Charge 7

> 7. *On 30 May 2022, you charged Patient A's account without her consent to do so.* ***NOT PROVED***

166. The GDC's case was that on 30 May 2022, Ms Horri charged Patient A's bank account £1080 without Patient A's consent.

167. In her evidence, Patient A stated that following the remedial appointment on 30 May 2022, Ms Horri debited £1080 without her consent.

168. The Committee had regard to a screenshot Patient A provided of a mobile banking application which showed a transaction being debited on 18 May 2022 for a total of *'£900.00'.* The reference for this payment is detailed as *'SUMUP*Elena'.* The icon next to the payment indicated that the payment was made via a contactless method and was authorised as *'Contactless digital wallet'.* Patient A confirmed this payment was made with her consent.

169. Patient A confirmed in her written statement and in her oral evidence that the payment for £900 was for her initial treatment for composite bonding on 17 May 2022. She stated that following her consultation with Ms Horri, during which it was agreed that Patient A would have composite bonding of upper and lower teeth and Zoom whitening treatment, she was informed that the total cost would be £900 (not inclusive of the £50 deposit paid at the booking of the appointment).

170. The Committee also had regard to a screenshot provided by Patient A of a mobile banking application which showed a transaction being debited on 31 May 2022 for a total of *'£1080.00'*. The reference for this payment was *'SUMUP*Elena'.* The icon next to the payment indicated that the payment was made as a debit card payment. No authorisation details were provided unlike the £900 charge, which did have authorisation details.

171. In Ms Horri's 'Rule 4' observations, she seemed to confirm that her records show Patient A was *'charged £2060 in total'* and did not appear to dispute that Patient A had been charged more than the £950 for the deposit and the initial treatment on 17 May 2022.

172. The Committee noted there were a number of concerns regarding the evidence in relation to the payment.

173. Patient A produced a "transaction screenshot" showing a debit of £1080.00 to "Elena" (Ms Horri) on 30 May 2022. This transaction screenshot was different from the screenshots of the two previous payments in that it did not have an authorisation method. The Committee was not provided with a copy of Patient A's bank statement showing this money being debited from her bank account.

174. Patient A's evidence was that it was her belief that Ms Horri must have stored her card details in order to take the payment. This was supposition by Patient A. In her 'Rule 4 observations', Ms Horri's explanation was that all sums taken were for treatment.

175. The GDC has not produced evidence as to how payments could have been taken from Patient A's bank account without the customer's consent. There is evidence of screenshots from Patient A's mobile banking application, but no expert evidence has been produced explaining how this could have been done.

176 The Committee did not see evidence of Patient A immediately raising the 'additional' charge of £1080, debited in May 2022, with Ms Horri. The Committee saw evidence of 'WhatsApp' messages in October 2022 between her and Ms Horri, raising this issue. In Patient A's written statement she said that she telephoned Ms Horri on 31 May 2022 in connection with the additional charge. This was inconsistent with Patient A's evidence of only ever communicating with Ms Horri via WhatsApp. In addition, Patient A told the Committee in her oral evidence that she had emailed Ms Horri in May 2022 but Patient A could not produce copies of these emails as she no longer had access to that email account. This again was inconsistent with her evidence that she only communicated via WhatsApp.

177. The Committee also considered it significant that Patient A did not raise this issue with the GDC in her original complaint and she did not raise it until 15 months later. Further, it noted that in Patient A's witness statement and in her oral evidence she maintained that she had raised the issue as a fraudulent transaction with her bank. She told the Committee that her bank investigated the matter and declined to uphold the complaint.

178. On the information before it, the Committee was unable to be satisfied that the GDC had discharged the burden of proof to show that this sum had been taken without Patient A's consent.

179. Accordingly, the Committee found **Charge 7 NOT proved.**

Charge 8

8. Your conduct in respect of 7 was dishonest in that you knew you did not have Patient A's consent to charge her account. ***NOT PROVED***

180. As the Committee has found the allegation that Ms Horri charged Patient A's account without her consent to do so not proved, it is not required to consider whether such conduct was dishonest.

181. Accordingly, the Committee found **Charge 8 NOT proved.**

Charge 9

9. *On 15 November 2023 you provided, via your lawyers, the following documents to the GDC:*

   a) *A patient questionnaire signed 05 May 2022 with a submission date of 17 May 2022* ***PROVED***
   b) *A patient questionnaire signed 07 May 2022 with a submission date of 07 May 2022* ***PROVED***
   c) *A patient questionnaire signed 17 May 2022 with a submission date of 17 May 2022* ***PROVED***
   d) *A patient questionnaire signed 05 July 2022 with a submission date of 07 May 2022* ***PROVED***
   e) *A consent form signed 17 May 2022 with a submission date of 17 May 2022* ***PROVED***
   f) *Transcript of WhatsApp chat with Patient A* ***PROVED***
   g) *Patient treatment records dated 7 May* ***PROVED***
   h) *Patient treatment records dated 17 May* ***PROVED***

182. The Committee noted an email from Clyde & Co, previously acting on Ms Horri's behalf, dated 15 November 2023 which included a number of attachments provided by Ms Horri.

183. These included:

- 4x treatment questionnaires said to have been completed by Patient A:

  - Signed 5 May 2022, submitted 17 May 2022 (Exhibit 1, page 269)
  - Signed 7 May 2022, submitted 7 May 2022 (Exhibit 1, page 255)
  - Signed 17 May 2022, submitted 17 May 2022 (Exhibit 1, page 252)
  - Signed 5 July 2022, submitted 7 May 2022 (Exhibit 1, page 271)

- A consent form said to have been signed by Patient A on 17 May 2022 and submitted on 17 May 2022 (Exhibit 1, page 264)

- Text-formatted copy of 13x 'WhatsApp' exchanges dated between 15 November 2022 and 10 December 2022 (Exhibit 1, page 273)

- 2x screenshots of computerised dental records for Patient A dated *'07/May'* and *'17/May'* (Exhibit 1, pages 275 and 277)

184. Therefore, the Committee found that Ms Horri had provided the documents to the GDC via her lawyers on 15 November 2023.

185. Accordingly, the Committee found **Charge 9 proved in its entirety.**

Charge 10

10. Your conduct in relation to 9a), 9b), 9c), 9d), 9e), above was:

a) Misleading, ***NOT PROVED***
b) Dishonest, in that the records purport to have been completed by Patient A but in fact were completed and/or edited by you. ***NOT PROVED***

186. The Committee bore in mind the earlier advice of the Legal Adviser in relation to dishonesty in its consideration of Charge 10. Actions or omissions can be misleading, intentionally or unintentionally.

Charge 10a)

187. The GDC's case is that the four patient questionnaires listed at Charges 9a) – 9d), and the consent form listed at Charge 9e), were not signed and completed by Patient A but had been completed and/or edited by Ms Horri.

188. The GDC relied upon the evidence of Patient A who stated that two of the signatures were not hers because it did not look like her *'fancy A'* that she used in her usual signature. The GDC also asserted that information as to Patient A's pregnancy and medication, which Patient A said she had put on the forms, has been edited after completion by Ms Horri.

189. The Committee reminded itself that there was no handwriting expert evidence before it. The Committee had significant concerns with the evidence presented to it and these included the following:

190. The Committee noted that there are some dates on the forms that caused some confusion. It was put to Patient A that it was possible that the dates may have been completed in the 'American format' (MM/DD/YYYY), rather than the 'British format' (DD/MM/YYYY). This was accepted by Patient A as a possibility. This would explain why Patient A's date of birth was recorded incorrectly and that the dates of '4' and '10' and months of April and October may have been 'switched around' as a result of this formatting issue. The Committee was satisfied that this would also explain how a patient questionnaire that was submitted on 7 May 2022 was signed on 5 July 2022, some two months in the future.

191. Patient A said she only completed two forms: one prior to the appointment for consent to tooth whitening on 7 May 2022 and one when she attended the 17 May 2022 appointment on the iPad provided to her when she waited in the reception area. This evidence is contradicted by Patient A's written evidence where she states that she signed four forms. She said that there are gaps in information in the documents and that parts of the form that she believed she had completed appear to be blank. This included that she was 20 weeks pregnant and that she was taking anti-depressant medication.

192. Patient A gave evidence that two of the signatures on the six forms provided were not hers. The Committee noted Patient A's evidence that the 'A' on the signature did not match her 'fancy' style of 'A'. Patient A confirmed that she signed the forms on her smartphone and on the iPad provided to her when she attended at Address A. The Committee considered that Patient A was not signing the documents with a pen and paper, but on electronic devices of varying sizes including a mobile telephone and an iPad. It therefore considered that it was possible that in using a finger to sign on the screen, the clarity of the individual letters may be affected, and Patient A's 'fancy A' could have been affected by this.

193. In any event, the Committee noted that to a lay person, the signatures did not look so different that it would be clear to the viewer that they were not all signed by the same person. Further, the Committee noted that the signatures that Patient A confirmed were hers had obvious differences.

194. In considering the inconsistencies, the Committee had regard to the tooth whitening consent form completed by Patient A on 7 May 2022 at 12:18. A copy of this form was sent directly to Patient A's email address upon completion of the online consent form from the provider, JotForm. The Committee found that despite Patient A's assertions that she did complete this information on the consent forms requested by Ms Horri, the information on the 'JotForm' questionnaire recorded:

Are you currently taking any medications? *No*
Do you have any medical conditions we should be aware of? *No*

195. Although Ms Horri would have been provided with a copy of the 'JotForm' questionnaire, the copy provided to the Committee was adduced by Patient A. This copy was emailed directly to Patient A following her completion and could not have been edited by anyone else, including Ms Horri.

196. The Committee also noted that the forms pertaining to have been completed by Patient A included two separate addresses. Patient A said she occasionally used a relative's address for the receipt of medical documentation. The relative also had received treatment from Ms Horri, but Patient A was certain that she did not provide that address to Ms Horri.

197. The Committee noted that due to the passage of time and Patient A's personal situation, it was possible that she may have been mistaken in a number of areas relating to the details in the completion of the forms. It did not consider that the information contained within the forms as so misleading that it would give the wrong impression to a treating clinician provided with the forms adduced. It was clear to the Committee that the information was largely similar in nature and consistent in itself, albeit with different addresses and different dates of birth, but bore in mind the potential explanations for these differences.

198. In light of the above, the Committee concluded that the GDC had not discharged the burden on it to show that Ms Horri's conduct was misleading in relation to documents for Patient A.

199. Accordingly, the Committee found **Charge 10a) NOT proved.**

Charge 10b)

200. For all the reasons detailed in its consideration of Charge 10a), the Committee did not consider that by providing the forms detailed in Charges 9a) – 9e) Ms Horri acted dishonestly. There was no evidence before the Committee that Ms Horri had completed the forms and purported completion by Patient A, or that she had edited the forms herself.

201. Therefore, the Committee concluded that the GDC had not discharged the burden on it to prove that Ms Horri had been dishonest.

202. Accordingly, the Committee found **Charge 10b) NOT proved.**

Charge 11

11. Your conduct in relation to 9f) was dishonest in that the entry in Schedule 1 purporting to be from Patient A was in fact made by you.
NOT PROVED

203. The GDC's case is that Ms Horri edited a 'WhatsApp' exchange between her and Patient A to insert an abusive comment, intending it to appear that it had been made by Patient A. This comment is set out in Schedule 1.

204. The GDC relied upon the evidence of Patient A who told the Committee that she would never use such language. Ms Horri's 'Rule 4 observations' stated that this was the 'WhatsApp' messages she had received from Patient A and that she stopped responding on receiving this language.

205. On questioning by the Committee, Patient A indicated that whilst she did not use such language, her travel companion who was with her that day did use such language and could have accessed her phone to write it, although she did not believe that he did.

206. The Committee considered in the circumstances that the GDC had failed to prove on the balance of probabilities that the abusive message was written by Ms Horri and therefore the allegation of dishonesty fails.

207. Patient A queried the authenticity of the 'WhatsApp' exchanges provided by Ms Horri as a text-formatted copy and raised her concerns that providing the messages in that format was easily editable, as opposed to providing screenshots which would be much more difficult to edit. Patient A explained that she was a prolific 'WhatsApp' user, accessing the application daily.

208. However, the Committee did not hear any evidence to establish if it was possible to delete 'WhatsApp' messages and that, if deleted, they would not show as an exchange on the screenshot.

209. The Committee did not consider that there was any benefit to Ms Horri for including the additional voice calls in her copy of the 'WhatsApp' exchanges, nor was there any real benefit to Ms Horri for alleging that the comment in Schedule 1 had been made if it had not.

210. Therefore, the Committee concluded that the GDC had not discharged the burden on it to demonstrate to the civil standard that Ms Horri had made the entry in schedule 1 or had been dishonest in providing it.

211. Accordingly, the Committee found **Charge 11 NOT proved.**

Charge 12

12. Your conduct in respect of 9g) and 9h) was:

a) Misleading, ***PROVED***
b) Dishonest, in that you have represented that the records relate to Patient A when they do not. ***NOT PROVED***

212. The Committee noted its earlier findings that the patient records provided for Patient A did not belong to her and likely belonged to another patient.

Charge 12a)

213. At the time Ms Horri was asked to provide documentation regarding Patient A to the GDC, she would have been aware that Patient A had made a complaint. Following a request from the GDC, Ms Horri provided copies of clinical notes for 7 May and 17 May 2022.

214. In the email from Clyde & Co dated 25 November 2023, it stated:

> *'I am instructed to relay that contemporaneous paper records were made for both 7 May and 17 May 2022 appointments in respect of this patient but, much to the registrant's frustration and embarrassment, she can no longer find these records and they are presumed lost. I am instructed to confirm these were simple blank paper records. Fortunately, the registrant was using a dual system where she was also making notes on her notepad/tablet (intended only as a draft, mainly to check at the end of the day to ensure the notes were correctly assigned to each patient and in case of any loss to her paper records) in respect of which she took a screenshot and we provide these for the GDC's attention. Fortunately, these screenshots of the notes, confirmed in the file properties as being taken on the day of each appointment and subsequently copied over from a device which the registrant is no longer in possession of, are sufficiently*

detailed so to enable a third party to understand the assessments undertaken together with treatment provided.'

215. The Committee considered it a possibility that Ms Horri had provided the records for 7 May and 17 May 2022 because the consent forms completed by Patient A were signed on 7 and 17 May 2022. The Committee considered that it was likely that the clinical notes belonged to another patient who had attended on those dates and Ms Horri had then provided those documents to the GDC in error. In doing so, Ms Horri had not ensured that the documents she provided were accurate and for the patient intended. The Committee considered this to amount to evidence of poor record keeping.

216. The submission of wrong patient records clearly has the potential to mislead the GDC.

217. Therefore, the Committee found **Charge 12a) proved.**

218. As at Charge 10, the Committee bore in mind the legal advice in relation to misleading conduct and dishonesty. In relation to dishonesty, the Committee first considered Ms Horri's likely state of knowledge or belief as to the facts.

219. The Committee noted its earlier findings that the consent forms signed by Patient A were dated 7 May and 17 May 2022 and there is the possibility that this led to the confusion in Ms Horri providing records for appointments on those dates to the GDC. It acknowledged that Ms Horri did have contact with Patient A on 7 May 2022, albeit via 'WhatsApp', and that she completed the consent forms and paid her deposit on that date.

220. In addition, the Committee noted that in her responses to Patient A following her complaint, Ms Horri described Patient A attending three appointments, rather than two. It was possible that Ms Horri may have confused Patient A with another patient; the Committee was aware that Ms Horri only performed cosmetic dentistry and that with such poor record keeping, it would have presented difficulties in determining which records belonged to which patient because of the similarities in the clinical records.

221. It was unclear to the Committee how Ms Horri would benefit from having sent the incorrect clinical records for Patient A. Further, the Committee considered it was highly unlikely that Ms Horri had amended the records before sending them as the information in the records is incorrect. The Committee considered it was more likely that, had Ms Horri dishonestly amended the records she provided, this would have been done to suggest that she had treated Patient A to a higher standard than the records actually demonstrate.

222. The Committee took account of the fact that poorly kept records can be misleading. In all the circumstances, the Committee concluded that the GDC had not discharged the burden on it to prove that Ms Horri had deliberately or dishonestly indicated (or represented) that the records related to Patient A when they did not.

223. Accordingly, the Committee found **Charge 12b) NOT proved.**

Charge 13

In the alternative to charge 12:

13. You failed to maintain an adequate standard of record keeping between 07 May 2022 and 30 May 2022 in that:

a) You recorded that Patient A's first appointment was on 7 May when in fact it was on 17 May,
b) You recorded that Patient A's second appointment was on 17 May when in fact it was on 30 May,
c) You did not record that you performed tooth whitening,
d) You recorded that you used the same shade at both appointments, when in fact you used different shades,
e) You did not record that you filed UR3, UR4, UL3 and UL4.

224. The Committee specifically heard from the GDC as to its position on Charge 13 if the Committee found that the submission of the wrong patient records was either misleading or dishonest. The GDC was clear that if either Charge 12a) or Charge 12b) were proved, the Committee should not consider Charge 13 which was clearly expressed as being *'in the alternative to Charge 12'.*

225. As the Committee has found that the records provided at Charges 9g) and 9h) did not belong to Patient A, and in having found Charge 12a) proved, Charge 13 falls away.

226. Accordingly, the Committee found **Charge 13 NOT proved.**

Charge 14

14. You failed to provide an adequate standard of care to Patient B on 26 January 2022 in that:-

a) *You did not undertake any or any adequate medical history from Patient B;* ***PROVED***
b) *You did not undertake any or any adequate assessment of Patient B's Covid-19 status;* ***NOT PROVED***
c) *You did not undertake any or any adequate occlusal assessment;* ***PROVED***
d) *You provided a poor standard of composite bonding to Patient B's UR1 in that:-*

    i. *The UR1 was bonded to the UL1,* ***PROVED***
    ii. *The composite bonding:-*
        a. *Was poorly contoured* ***NOT PROVED***
        b. *Was of a poor aesthetic result* ***NOT PROVED***
        c. *Had overhanging margins* ***PROVED***
        d. *Left Patient B with bite problems* ***PROVED***

e) *You provided a poor standard of composite bonding to Patient B's UL1 in that:-*

    i. *The UL1 was bonded to the UL2* ***PROVED***
    ii. *The composite bonding:-*
        a. *Was poorly contoured* ***PROVED***
        b. *Was of a poor aesthetic result;* ***PROVED***
        c. *Had overhanging margins* ***PROVED***
        d. *Left Patient B with bite problems* ***PROVED***

Charge 14a)

227. The Committee was aware that it had no statement or the original complaint from Patient B, and had to determine this charge on Patient B's clinical records alone. The Committee was unable to identify anywhere in the records that a medical history was taken prior to commencing treatment on 26 January 2022.

228. In Dr Nichols' expert report, she stated:

> *'There is no evidence that the Registrant undertook a medical history. The 2013 GDC standard states "4.1.1 You must make and keep complete and accurate patient records, including an up-to-date medical history, each*

time that you treat patients." This would typically include socio-behavioural history such as drinking and smoking. In my opinion, this failure is far below the expected standard as it is a mandatory requirement and patients can be put at risk if their medical history is not checked. If the medical history was taken but just not recorded, in my opinion, this would be below but not far below the expected standard as the Patient would not have been put at risk.'

229. The Committee noted that in the 'Rule 4' observations, there is a brief background to the appointment, including reference to examinations undertaken and discussions had prior to starting treatment. A consent form was also referred to, which has been seen by the Committee. However, there is no reference in these documents to a medical history being taken by Ms Horri.

230. The Committee considered that it was more likely than not that in not being recorded or recalled, a medical history had not been taken.

231. In this regard, it accepted the evidence of Dr Nichols and concluded that it is a mandatory requirement to take a patient's medical history before treatment.

232. Therefore, the Committee was satisfied that by not undertaking any medical history from Patient B, Ms Horri failed to provide an adequate standard of care.

233. Accordingly, the Committee found **Charge 14a) proved.**

Charge 14b)

234. Having considered Patient B's clinical records, the Committee noted that there was no evidence that Ms Horri undertook an assessment of Patient B's COVID-19 status. In her expert report, Dr Nichols referred to the example questions that were expected and to the guidance issued by the government, *'COVID-19: infection prevention and control dental appendix (Updated 14 April 2022)',* referred to hereafter as 'the COVID Guidance'.

235. In Patient B's clinical records, there is an entry for 26 January 2022, as follows:

26/01/2022

Composite Bonding- OCCASIONAL PATIENT
PATIENT REQUEST CONSULTATION/EXAMINATION/TREATMENT
WITH REGARDS TO PRESENTING COMPLAINT ONLY.

COVID-19.
PATIENT GIVEN THE FOLLOWING INFORMATION:DUE TO COVID-19 PANDEMIC, MANAGEMENT OF PRESENTING
COMPLAINTS LIMITED TO DENTAL
ADVICE,MEDICATION,TEMPORARY FILLINGS AND NON-SURGICAL EXTRACTIONS AS
PER GOVERNMENT GUIDELINES.
THE FOLLOWING PROTECTIVE CLINICAL WEAR WAS USED BY MYSELF THIS CONSULTATIONS/ TREATMENT :
1. DISPOSABLE SURGICAL GOWN2. DISPOSABLE SURGICAL HAIR CAP3. FACE MASK VISOR4. FFP-3 MASK5.
DISPOSABEL LATEX FREE GLOVES

IN ORDE TO OBSERVE GOVERNMENT GUIDELINES WITH REGARDS TO CLOSE CONTACT AND TO REDUCE FOOT TRAFFIC
IN THE RECEPTION AREA,PATIENTS ARE ENCOURAGED TO ATTENT THEIR EMERGENCY APPOINTMENTS ALONE OR TO BE ACCOMPANIED BY MAXIMUM ONE OTHER PERSON. IN ORDER TO OBSERVE GOVERNMENT GUIDELINES WITH REGARDS TO CLOSE CONTACTS AND TO REDUCE FOOT TRAFFIC IN THE RECEPTION AREA, RECEPTION IS CONTACTED TO CONFIRM ITS IS SAFE TO DISCHARGE PATIENT TO THE RECEPTION AREA AFTER COMPLETION OF TREATMENT.

236. In her opinion, Dr Nichols stated that:

> *'There is no evidence that the Patient was asked Covid screening questions. This was mandatory in early 2022 as per guidance* [referred to in her report]*. In my opinion, this failure was far below the expected standard as failing to check if a patient had any symptoms of Covid could risk avoidable spread of the disease. If the Patient was asked Covid screening questions and this was simply not recorded, then in my opinion, this would be a minor record keeping area* [error] *and suboptimal but not below an acceptable standard.'*

237. The Committee noted that the COVID Guidance was withdrawn on 27 May 2022, and it was therefore applicable at the relevant time. There was no evidence that Ms Horri undertook any assessment based on the records provided. In particular, despite the mention of the COVID-19 information Ms Horri provided to Patient B, there is nothing recorded regarding what screening was undertaken.

238. In its consideration of whether this amounted to a failure to provide an adequate standard of care, the Committee bore in mind Ms Horri's practice at that time. It is evident from the records that she was applying the 'Respiratory pathway', which employed all Personal Protective Equipment (PPE) in line with an assumption that all patients had COVID-19. The Committee considered that this was a high standard of care and in those circumstances, Ms Horri not undertaking a COVID-19 assessment did not amount to a failure to provide an adequate standard of care to Patient B.

239. Accordingly, the Committee found **Charge 14b) NOT proved.**

Charge 14c)

240. In Patient B's records, Ms Horri had recorded the following entry:

> *'Patient wants to change the colour and shape of ul1,uR1*
>
> *E/O: TMJ nil/ LN nil/ Lips: Nil/ Facial Symmetry nil*
> *I/O: Tongue nil, FOM nil, Palate nil, Mucosa nil, Gingivae nil*
> *PROVISIONAL DIAGNOSIS:*
>
> *Observations:*
> *UL1- root filled,discolored*
> *BPE 112 121'* [sic]

241. Having observed this entry, the Committee was satisfied that there is no record of an assessment of the occlusion.

242. Dr Nichols opined that assessing the occlusion was important in assessing the crowding of the teeth. In her expert report, she stated:

> *'[Patient B] had a Class 1 (normal) bite relationship with crowding of the upper and lower anterior teeth. This would have been relevant to the composite bonding, as it would affect whether or not composite bonding would achieve the best outcome. There is no record of occlusal assessment noting the bite relationship and crowding. If the occlusion was not assessed at all I would consider this far below the expected standard because the crowding of the teeth means that the best outcome in this case would have been orthodontic treatment, following by internal tooth whitening of the discoloured root canal treated tooth. There is no evidence that this was considered. If the occlusion was assessed but this was not recorded then this would be sub-optimal but acceptable.'*

243. The Committee accepted Dr Nichols' evidence that it was below an acceptable standard to have not assessed the occlusion before undertaking the course of treatment decided upon. There was no evidence before the Committee that Ms Horri undertook an occlusal assessment.

244. The Committee was satisfied, given the intended treatment, that an occlusal assessment was needed and its absence amounted to a failure to maintain an adequate standard of care.

245. Accordingly, the Committee found **Charge 14c) proved.**

Charge 14d)

246. The Committee noted that Charge 14d) related to the standard of composite bonding for UR1. In assessing this, the Committee noted that Image 1 of the photographs referred to by Dr Nichols in her expert report (Exhibit 1, page 330) appeared to be a mirror image of Image 2 and Image 3. For reference, the Committee used the pre-operative photograph provided of Patient B's teeth as the baseline for determining the position of the teeth.

Charge 14d)i

247. In her expert report, Dr Nichols stated:

> *'In my opinion, the composite bonding was far below the expected standard because the photos show … the teeth were bonded together which would impede oral hygiene risking caries and periodontal disease.'*

248. Having considered the photographs of Patient B's teeth following the composite bonding treatment, the Committee agreed with Dr Nichols' opinion that UR1 and UL1 were bonded together with composite material; it was clear that there is no gap between them when viewed from the front and from underneath.

249. The Committee noted in Ms Horri's 'Rule 4' observations that, *'During the course of the appointment, Pt B stated that she wished for the gaps be filled (between the UR1 and UL1) … this appears in the contemporaneous record for this appointment.'*

250. In Patient B's clinical records, Ms Horri has recorded the following entry:

'Patients is not stable and keep moving her head and talking ,she was advised to stop ,she requested that gaps be filled and she was explained it s against clinical advice but she requested to be like that'.

[sic]

251. In determining whether this amounted to a poor standard of treatment, the Committee considered Dr Nichols' report, which stated:

'I note the conflict of fact regarding whether or not the Patient asked the teeth to be bonded together. This seems unlikely but in any event, even if a patient asked for a teeth to be bonded together and was informed of the risks, it would not be acceptable to do this due to the risks of caries and periodontal disease. In my opinion, this would constitute a failing far below the expected standard as it is simply something that no reasonable dentist would consider doing due to the risks above. If a patient was requesting "gaps to be filled" it would be important to ascertain what they were referring to when they said "gaps" as this can be a shape issue which can be resolved with well-contoured bonding without bonding teeth together.'

[sic]

252. In the notes of the subsequent treating dentist, the Committee acknowledge the following entry in Patient B's clinical records:

'Teeth 11, 21 and 22 bonded together- Unable to floss or clean area'.

253. The Committee accepted the evidence of Dr Nichols that by bonding UR1 and UL1 together, this would impede oral hygiene and increase the risk of caries and periodontal disease. This was apparently accepted by Ms Horri in her 'Rule 4' observations, in which it was stated:

'[Ms Horri] has carefully reviewed the records of the subsequent treating dentist and notes the comments that have been made regarding the treatment she undertook, specifically the reference to not two but three teeth that had been bonded together… [Ms Horri] wishes to highlight that she has absolutely no recollection of bonding the UL1 and UL2 together, but she accepts the subsequent treating dentists' records in respect of this. [Ms Horri] accepts full responsibility for this and apologises to Patient [B] and the GDC.'

254. In light of all the information available to it, the Committee was satisfied that in bonding UR1 and UL1 together, Ms Horri provided a poor standard of composite bonding to UR1 and consequently failed to provide an adequate standard of care.

255. Therefore, the Committee found **Charge 14d)i proved.**

Charge 14d)ii.a.

256. In assessing the contouring of UR1, the Committee had regard to the photographs provided and Dr Nichols' expert report. Dr Nichols opined that the photographs show a very poor aesthetic result, including poor contouring which would cause gingival inflammation.

257. However, in its own assessment of the photographs, the Committee did not agree with Dr Nichols' opinion as it considered that the material on UR1 was relatively flat and created a more uniform look to the UR1. The Committee determined that whilst the contouring may not be of a 'gold' standard, it was acceptable in the circumstances.

258. Accordingly, the Committee found **Charge 14d)ii.a. NOT proved.**

Charge 14d)ii.b.

259. As with Charge 14d)ii.a., the Committee noted the opinion of Dr Nichols but did not agree that the composite bonding was of a poor aesthetic result. The Committee considered, having examined the photographs, that the composite bonding on UR1 did not, in isolation, have a poor aesthetic result.

260. Accordingly, the Committee concluded that Ms Horri did not provide a poor standard of composite bonding as UR1 was not of a poor aesthetic result.

261. Therefore, the Committee found **Charge 14d)ii.b. NOT proved.**

Charge 14d)ii.c.

262. In her expert report, Dr Nichols indicated on the photographs where she considered there to be evidence of overhanging margins. She noted that these overhangs would impede Patient B's oral hygiene.

263. The Committee also noted Patient B's clinical records provided by the subsequent treating dentist and the entry that states:

'Overhang at cervical margin, as well as palatal'.

264. The Committee had careful regard to the photograph provided and acknowledged that there were overhanging margins, at the mesial aspect and distal aspect of UR1. It was clear from the photographs that the composite material applied by Ms Horri had resulted in overhanging margins as the composite material extended beyond the natural gumline. It accepted Dr Nichols' evidence that, in doing so, this would negatively affect Patient B's ability to maintain adequate oral hygiene.

265. Therefore, the Committee was satisfied that Ms Horri provided a poor standard of composite bonding to Patient B's UR1 in that it had overhanging margins and consequently failed to provide an adequate standard of care.

266. Accordingly, the Committee found **Charge 14d)ii.c. proved.**

Charge 14d)ii.d.

267. The Committee noted that Dr Nichols agreed with the subsequent treating dentist that the composite bonding had created a bite problem for Patient B. She noted on the photographs in her expert report where she considered there to be evidence of a bite problem resulting from Ms Horri's composite bonding of UL1 and UR1. Patient B's clinical notes from the subsequent treating dentist recorded the following:

'Urgent appointment:
CO-bonding done yesterday- looks terrible, is hurting, cannot bite'.

268. In her 'WhatsApp' message to Ms Horri on 27 January 2022, Patient B stated, *'I went to see my dentist who told me the 2 front teeth was bonded together with no gaps they was uneven and I had so much bonding behind the teeth It effected My bite…'* [sic]

269. On its inspection of the photographs provided, the Committee noted that the biting edge of UR1 had a small chip in the composite material. Although the Committee did not have a photograph of this angle from the immediate aftermath of the treatment, it considered it highly unlikely that the chip was present when Patient B left the appointment and it was more likely than not that the chip had occurred as a result of Patient B biting down.

270. In the absence of any occlusal assessment, the Committee could not be certain of the cause of the chip, but was satisfied that it was more likely than not that if the whole incisal edge of UR1 was covered with composite material that this would have affected

a patient's bite and would likely have resulted in damage to the composite, as shown in the photograph.

271. Therefore, the Committee was satisfied that Ms Horri provided a poor standard of composite bonding to Patient B's UR1 in that it left Patient B with a bite problem and consequently failed to provide an adequate standard of care.

272. Accordingly, the Committee found **Charge 14d)ii.d proved.**

Charge 14e)i.

273. In line with its earlier findings on Charge 14d)i, the Committee was satisfied that UL1 was bonded to UL2. It reassessed the photographs provided in the same way as it approached Charge 14d)i and noted that there was composite material between UL1 and UL2.

274. The Committee also bore in mind Ms Horri's 'Rule 4' observations in which she accepted unreservedly the standard of care she provided must have been deficient having seen Patient B's clinical records provided by the subsequent treating dentist.

275. For these reasons, the Committee was satisfied that in line with its reasons at Charge 14d)i, Ms Horri provided a poor standard of composite bonding in that UL1 was bonded to UL2 and consequently failed to provide an adequate standard of care.

276. Accordingly, the Committee found **Charge 14e)i proved.**

Charge 14e)ii.a

277. Unlike its finding at Charge 14d)ii.a., the Committee accepted the opinion of Dr Nichols. Having assessed the photographs of Patient B it noted that the contouring on UL1 was uneven and not as flat and uniform as UR1.

278. In this regard, the Committee was satisfied that Ms Horri did deliver a poor standard of composite bonding in that UL1 was poorly contoured and consequently failed to provide an adequate standard of care.

279. Accordingly, the Committee found **Charge 14e)ii.a. proved.**

Charge 14e)ii.b.

280. In light of the poor contouring to UL1, the Committee considered whether this resulted in a poor aesthetic result. Ms Horri recorded in her notes for Patient B's appointment that Patient B had requested composite bonding for the following reasons:

> *'TOOTH DISCOLORATION,IMPROVING OVERAL AESTHETIC OF TWO UPPER FRONTAL TEETH'.*
> [sic]

281. The Committee bore in mind the 'WhatsApp' messages sent to Ms Horri in which Patient B stated that, when she had showed her family the result of the treatment, they described her teeth looking *'awful'.* Further, the clinical records provided by Patient B's subsequent treating dentist reported the patient complaining that the treatment looked *'terrible'.* The subsequent treating dentist recorded, *'Aesthetically does not match adjacent teeth.'* This opinion was supported by Dr Nichols in her expert report.

282. Having examined the photographs of UL1, the Committee noted that the composite material appeared very thick and continued onto the biting edge of the tooth, which looked bulky and unnatural, which did not improve the overall aesthetic of the two upper front teeth.

283. Therefore, the Committee agreed with Dr Nichols' opinion and was satisfied that Ms Horri had delivered a poor standard of composite bonding to Patient B's UL1 in that it was of a poor aesthetic result and consequently failed to provide an adequate standard of care.

284. Accordingly, the Committee found **Charge 14e)ii.b. proved.**

Charge 14e)ii.c.

285. The Committee had regard to the clinical records provided by Patient B's subsequent treating dentist which stated, *'Overhang at cervical margin, as well as palatal.'* This was evident in the photographs referred to by Dr Nichols where it was apparent that the composite material extended over the natural gumline. Dr Nichols indicated on the photographs where she considered the composite to have overhanging margins. The Committee could itself see that there was composite overhanging the margins on the distal edge of UL1, going towards UL2.

286. In line with its findings at Charge 14d)ii.c., the Committee accepted Dr Nichols' evidence that the overhanging of composite material would impede Patient B's ability to maintain adequate oral hygiene

287. Therefore, the Committee was satisfied that Ms Horri had delivered a poor standard of composite bonding to Patient B's UL1 in that it had overhanging margins and consequently failed to provide an adequate standard of care.

288. Accordingly, the Committee found **Charge 14e)ii.c. proved.**

Charge 14e)ii.d.

289. In line with its earlier findings and for the same reasons it has detailed at Charge 14d)ii.c., the Committee was satisfied that Ms Horri had delivered a poor standard of composite bonding to Patient B's UL1 in that it left Patient B with bite problems and consequently failed to provide an adequate standard of care.

290. Accordingly, the Committee found **Charge 14e)ii.d. proved.**

Charge 15

> *15. On 29 March 2022 you sent an email to Patient B accusing her of acting with* "bad intent" *and threatening legal action for raising a complaint.* ***PROVED***

291. The Committee had regard to an email from Ms Horri's email address to Patient B, dated 29 March 2022.

292. The email is addressed to Patient B and states:

> *'Dear [Patient B]*
>
> *As we refunded you still act with a bad intent towards me. You accused me as of not being registered on GDC, you accused me of lying and not refunding you. While all of my information clearly is on the website you still claim I am not registered on GDC.*
> *A false accusation, Libel, slander are all punishable in court. False defamatory libel punishable by imprisonment and fine under defamation act 2013, and Libel Act 1843.*
> *This is an email to notify you are aware of your action and in full mental capacity. Next step we take a strong legal action for financial loss and defamation of character.*
>
> *You will hear from my solicitors.*

DR ELENA.'
[sic]

293. The Committee was therefore satisfied that Ms Horri did send an email to Patient B accusing her of acting with *"bad intent"* and threatening legal action for raising a complaint on 29 March 2022.

294. Accordingly, the Committee found **Charge 15 proved.**

Charge 16

16. Your conduct in relation to 15 above:-

a) Unprofessional ***PROVED***
b) Failed to respect Patient B's right to complain. ***PROVED***

295. Having had regard to the context of the email and the use of words contained within it, the Committee was satisfied that by accusing Patient B of acting with *"bad intent"* and threatening legal action for raising her complaint, Ms Horri was unprofessional.

296. Accordingly, the Committee found **Charge 16a) proved.**

Charge 16b)

297. The Committee was satisfied that Ms Horri had a duty to respect Patient B's right to complain. Standard 5.2 states that you must respect a patient's right to complain, specifically in 5.2.1: "*You should not react defensively to complaints. You should listen carefully to patients who complain and involve them fully in the complaints process. You should find out what outcome patients want from their complaint.*"

298. In her 'Rule 4' observations, Ms Horri accepted that her *'communication and general complaint handling manner clearly did not meet the expected standard.'*

299. The Committee was satisfied that the language and words used by Ms Horri in her email dated 29 March 2022 did amount to a defensive reaction and was in breach of that standard. For those reasons, the Committee was satisfied that Ms Horri had not respected Patient B's right to complain.

300. Accordingly, the Committee found **Charge 16b) proved.**

Charge 17

17. As practice principal you have failed to register the following locations with the Care Quality Commission:

a) Address A ***PROVED***
b) Address C ***PROVED***

301. The Committee bore in mind the oral and documentary evidence of Witness 1, an Enforcement Manager for the CQC, and Dr Stankiewicz, Specialist Adviser Dentists for the CQC, in its consideration of this charge.

302. In coming to its decision, the Committee first considered whether Ms Horri was under an obligation to register her dental premises with the CQC.

303. Witness 1 told the Committee that the practice principal is legally responsible for registration with the CQC for the regulated activity being performed at their dental setting. The regulated activity includes diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury. Witness 1 stated that once registered as a legally entity, an application must be made by them to undertake regulated activity and provide the addresses from which they intend to practise. Following receipt of the application, the CQC must authorise those addresses connected to the legal entity. Witness 1 stated that it is an offence under section 10 of the *'Health and Social Care Act 2008'* to carry on regulated activities without registration with the CQC.

304. The Committee had regard to the document, *'Working Arrangements and Indemnity Insurance'* provided at the GDC's request, which showed that Ms Horri was the practice principal. She listed herself as *'Principal Elena Horri 291568'* alongside Address A and Address C as the dental practices' addresses. In addition, Ms Horri recorded her *'Employment status'* as *'Practice principal'* for both addresses.

305. Witness 1 confirmed that between January 2021 and December 2023, Ms Horri was not registered as a legally entity and that Address A and Address C were not registered with the CQC. In addition, she confirmed that there were no applications been made in Ms Horri's name in relation to Address A and Address C.

306. Therefore, the Committee found Ms Horri failed to register Address A and Address C with the CQC in her role as practice principal.

307. Accordingly, the Committee found **Charge 17 proved.**

Stage 2 (12 – 13 February 2026)

308. Having announced its decision on the facts found proved in this case on 21 November 2025, the Committee resumed hearing Ms Horri's case between 12 and 13 February 2026. Ms Horri did not attend the hearing and was not represented. Mr Omar Soliman, Counsel, appeared on behalf of the GDC. The hearing was conducted remotely on Microsoft Teams.

309. Mr Soliman firstly invited the Committee to determine whether the hearing should proceed in Ms Horri's absence. Ms Horri had not attended on any of the previous dates when this hearing had taken place (21 July to 1 August 2025; 19, 22 and 26 September 2026 and 21 November 2025). The Committee had also previously determined on 21 July 2025 that it was fair and in the public interest that the hearing should proceed in Ms Horri's absence.

310. Notwithstanding the Committee's previous decision, however, Mr Soliman submitted that the Committee should consider whether it should proceed with the hearing on 12 February 2026 in Ms Horri's absence out of fairness to her. He acknowledged that proceeding in the absence of a registrant in a part-heard hearing was not covered in the GDC (Fitness to Practise) Rules Order of Council 2006 ('the GDC Rules').

311. Mr Soliman submitted that Ms Horri had been made aware that the hearing would be resuming on 12 February 2026 by letter, dated 13 January 2026, sent to both her overseas registered address and to an additional address in the UK. He submitted that Ms Horri is well aware of today's hearing date and these proceedings and has made no effort to join. He submitted, therefore, that it would be appropriate to proceed in Ms Horri's absence.

312. The Committee heard and accepted legal advice on this matter.

Decision on Service of the Notice of Hearing and on Proceeding in the Registrant's Absence (12 February 2026)

313. The Committee received from the GDC an indexed hearing bundle, titled *'Proceeding in Absence Bundle'*, of 84 pages, which contained a copy of the GDC letter, dated 13 January 2026, to Ms Horri notifying her that the hearing would be resuming from 12 to 13 February 2026. The letter was sent to Ms Horri's registered address overseas by

'International Track and Signed', 'International Standard Delivery' and secure email. The letter was also sent to Ms Horri's UK address.

314. The Committee had regard to the GDC Rules, but noted that they were silent in respect of notifying registrants of resumed dates for part-heard hearings. Nonetheless, the Committee was satisfied that the above letter sent to Ms Horri contained proper notification of today's resumed hearing. This included the date and that it will be taking place remotely on Microsoft Teams, and the notification that the Committee had the power to proceed with the hearing in Ms Horri's absence.

315. On the basis of the information provided, the Committee was satisfied that Ms Horri had received sufficient notice and had been appropriately informed of today's resumed hearing.

316. The Committee next considered whether to exercise its discretion to proceed with the hearing in the absence of Ms Horri. Again, the Committee noted that there is no specific reference in the GDC Rules to proceeding in a Registrant's absence in resumed part-heard hearings. Nonetheless, the Committee approached the issue with the utmost care and caution. It took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones (Anthony) [2002] UKHL 5* and *GMC v Adeogba & Visvardis [2016] EWCA Civ 162*. It remained mindful of the need to be fair to both Miss Horri and the GDC, taking into account the public interest and Miss Horri's own interests.

317. The Committee noted that Ms Horri had not responded to the GDC's letter of 13 January 2026. It noted that the GDC had made all reasonable efforts to notify Ms Horri of when the hearing would be resuming. The Committee also had regard to its previous decision to proceed in Ms Horri's absence, and it noted that she had not attended on any of the previous days that this hearing has taken place.

318. The Committee concluded therefore that Ms Horri had chosen not to attend today's hearing. The Committee determined that it should proceed in Ms Horri's absence having regard to the public interest in the expeditious disposal of cases. It concluded that no useful purpose would be served by an adjournment of this hearing as it was clear that Ms Horri would not attend any future hearing.

319. In those circumstances, the Committee determined that it was fair and appropriate to proceed with the hearing in the absence of Ms Horri.

Summary of the Committee's Findings of Fact

320. The Committee found proved the following charges in respect of Patient A and Patient B:

Patient A

- 1(a) – not carrying out sufficient diagnostic assessments in that Ms Horri did not conduct a cosmetic assessment of the upper anterior teeth;
- 1(b) – not carrying out sufficient treatment planning;
- 1(c) (ii) and (iv) – provided a poor standard of treatment in relation to composite bonding in that the composite bonding had a superficial layer that was poorly bonded to the underlying layer, and that margins were rough even and overhanging.
- 2(c) – Not obtaining informed consent for treatment provided to Patient A between 7 May 2022 and 30 May 2022 in that she filed four teeth without Patient A's consent;
- 4(c) – failing to treat Patient A with kindness and compassion in that she was left alone whilst undergoing tooth whitening, and Patient A's safety was put at risk.
- 5 – providing dental treatment without adequate support;
- 6 – put Patient A's safety at risk - proved in respect of 4(c);
- 9 – provision of documents via Ms Horri's lawyers;
- 12(a) – The provision of Patient Treatment records dated 7th May (9g) and 17th May (9h) was misleading.

Patient B

- 14 (a) – Failed to provide an adequate standard of care to Patient B by not undertaking any or any adequate medical history;
- 14 (c) – Failed to provide an adequate standard of care to Patient B by not undertaking any or any adequate occlusal assessment;
- 14 (d) – Failed to provide an adequate standard of care to Patient B by providing a poor standard of care in respect of composite bonding in that:

  i. UR1 was bonded to UL1
  ii.(c) The composite had overhanging margins on UR1
  ii. (d) Patient B was left with bite problems on UR1

- 14 (e)(i) UL1 was bonded to UL2
  (e) (ii)(a) The composite was poorly contoured on UL1

(e)(ii)(b) The composite had a poor aesthetic result on UL1
(e)(ii)(c) Patient B was left with overhanging margins on UL1
(e)(ii) (d) Patient B was left with bite problems on UL1

- 15 and 16 – acted in an unprofessional manner, and failed to respect Patient B's right to complain having accused Patient B of acting with a bad intent and threatening legal action for raising a complaint;
- 17 – as a practice principal Ms Horri failed to register two locations with the Care Quality Commission.

Documents

321. The Committee had regard to a Stage 2 bundle provided by the GDC. This comprised the GDC's Stage 2 written submissions, a separate PCC determination regarding another case in respect of Ms Horri and written representations from Ms Horri (undated, but received by the GDC on 1 December 2025).

322. The Committee next went on to consider whether the facts found proved amounted to misconduct and, if so, whether Ms Horri's fitness to practise is currently impaired by reason of her misconduct, and if so, what sanction, if any, should be imposed. In accordance with Rule 20 of the GDC Rules, the Committee heard submissions from Mr Soliman on these matters.

Submissions

323. Mr Soliman informed the Committee that he would be relying on the written submissions and would highlight the key points.

324. Mr Soliman first addressed the Committee in respect of Ms Horri's fitness to practise history. He submitted that on 12 November 2025, a separate PCC had found Ms Horri's fitness to practise impaired by reason of misconduct and had suspended her registration for 12 months. He submitted that the facts found proved in that case had similar features to this case and occurred around the same time. These factors included putting patient safety at risk, failing to follow proper procedural requirements and failing to communicate in a professional manner.

325. In respect of misconduct, Mr Soliman took the Committee through the GDC Standards, which he submitted had been breached by Ms Horri. He submitted that the facts found proved can properly be judged as misconduct for the following reasons. He submitted that patient harm had occurred to both patients in this case. Furthermore, Ms Horri had contributed to the harm or the risk of harm by failing to carry out the relevant risk

assessments and proper treatment planning for both patients. Ms Horri continued to pose a risk of harm to Patient A (who was pregnant at the time of treatment) by leaving her alone during treatment and not having sufficient support. In respect of Ms Horri's misleading behaviour towards the GDC and failing to properly engage with its investigation, he submitted that this clearly fell below the standards expected. Lastly, he submitted that Ms Horri's unprofessional conduct in respect of Patient B's complaint and her failure to register her two practices with the Care Quality Commission (CQC) fell far below the expected standard.

326. In respect of impairment, Mr Soliman submitted that Ms Horri's fitness to practise is impaired in respect of both components, public protection and the public interest. He submitted that the clinical failings are remediable, but there is no evidence that they have been remedied. He submitted that there is no evidence of strengthened practice from Ms Horri as she is currently not working in dentistry. Furthermore, he submitted that Ms Horri's unprofessional conduct in response to Patient B's complaint points towards an attitudinal issue that is more difficult to remediate.

327. Mr Soliman submitted that the following elements of the case particularly touch upon the public interest:

- Misleading communication with the GDC;
- Working without adequate assistance;
- The failure to properly engage with a meaningful complaints procedure;
- Not registering with the CQC.

328. With regard to sanction, Mr Soliman invited the Committee to impose a suspension order on Ms Horri's registration for a period of 12 months with a review hearing. He submitted that this would be the appropriate and proportionate sanction for the following reasons:

- Ms Horri has taken action with the potential to mislead her professional regulator;
- Ms Horri's conduct has resulted in multiple serious and repeated departures from the relevant professional standards;
- Harm to both patients has occurred in that both patients required remedial treatment to remove and redo the bonding by their respective subsequent treating dentists. Enamel damage ensues from this redo. Patient A's canines have been permanently altered.
- There is a continuing risk of harm to patients as Ms Horri has not remediated her misconduct.
- There appears to be a persistent lack of insight by Ms Horri into the seriousness of her actions and consequences.

- In respect of the failure to register with the CQC, Ms Horri failed to comply with her legal obligations as practice principal and left patients without the quality assurance that registration provides.

329. Mr Soliman also addressed the Committee regarding the imposition of an immediate order. He submitted that an immediate order would not be necessary as Ms Horri is currently suspended in respect of her other case.

Committee's Decision

330. The Committee has borne in mind that its decisions on misconduct, impairment and sanction were matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's *Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020)* (the GDC's Guidance). The Committee also received advice from the Legal Adviser which it accepted. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

331. The Committee had regard to the GDC's *Standards for the Dental Team (2013)* (the GDC Standards) and determined that Ms Horri's conduct represented a serious departure from the following GDC Standards:

1.2.3: You must treat patients with kindness and compassion.

1.9: You must find out about laws and regulations that affect your work and follow them.

2.3.6: You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan.

3.1: You must obtain valid consent before the starting treatment, explaining all the relevant options and the possible costs.

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

5: Have a clear and effective complaints procedure

6.2.1: You must not provide treatment if you feel that the circumstances make it unsafe for patients

6.2.6: Medical emergencies can happen at any time. You must make sure that there is at least one other person available within the working environment to deal with medical emergencies when you are treating patients. In exceptional circumstances the second person could be a receptionist or a person accompanying the patient.

7.1: You must provide good quality care based on current evidence and authoritative guidance.

9.4: You must co-operate with any relevant formal or informal enquiry and give full and truthful information.

332. The Committee considered that Ms Horris had breached a number of GDC Standards. It had found that she had caused permanent harm to two patients and posed a risk of harm throughout her case to both of those patients. She had also failed to register two of her practices with the CQC, despite warnings from other dental professionals that she was obligated to do so. Furthermore, she had engaged in misleading behaviour towards the GDC and displayed unprofessional behaviour towards Patient B when Patient B had complained about her treatment.

333. The Committee determined, therefore, that the failings in this case were sufficiently serious to amount to a finding of misconduct.

Impairment

334. The Committee then considered whether Ms Horri's fitness to practise was currently impaired by reason of her misconduct.

335. The Committee first sought to determine whether Ms Horri had shown any insight into her clinical failings and overall misconduct. It noted that Ms Horri had not attended this hearing and had shown minimal engagement with the GDC's investigation. The Committee considered Ms Horri's written Rule 4 observations in respect of Patient A and Patient B's case, dated 23 June 2023 and 12 June 2024 respectively. It also had regard to Ms Horri's most recent written representations, which were undated but received by the GDC on 1 December 2025. It noted in respect of Patient B's case, that she had offered to undertake remedial action to correct the bad dentistry, albeit this was not taken up by Patient B. Furthermore, in the Rule 4 observations dated 23 June 2023, Ms Horri, via her lawyers, offered an apology in respect of her response to Patient B's

complaint. However, the Committee could find no further evidence that Ms Horri has acknowledged fault, apologised for her actions, recognised that she should have behaved differently in the circumstances or put in place measures to ensure that they would not be repeated. Instead, the Committee noted that Ms Horri appeared to make excuses for her behaviour and had invited the GDC in December 2025 to *'voluntarily revoke all sanctions currently in place against me'*. The Committee determined, therefore, that she has demonstrated a lack of understanding of the seriousness of the matters in this case and has persistently lacked insight into her misconduct.

336. The Committee noted that the concerns in Ms Horri's case were wide-ranging, included clinical and non-clinical matters, and involved multiple breaches of the GDC Standards. In respect of her clinical misconduct, which led to both patients suffering permanent harm, the Committee has seen no evidence from Ms Horri that she has remedied these clinical concerns. Furthermore, the Committee has received no evidence of remediation in respect of the non-clinical matters, including her unprofessional behaviour in responding to complaints, her failure to comply with the legal requirements regarding registering her two practices with the CQC and her misleading behaviour towards the GDC regarding its investigation.

337. The Committee considered therefore, without any current evidence of remediation or insight, there is a significant risk that Ms Horri could repeat the misconduct it has found. In the Committee's view a finding of impairment is necessary for public protection.

338. The Committee also determined that a finding of impairment was necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and behaviour among dental professionals. In particular, the Committee considered that, given Ms Horri's failure to comply with her legal obligations by not registering her practices with the CQC, the fact that she left a vulnerable patient unsupervised during treatment and her minimal engagement with the GDC, a reasonable and informed member of the public would lose confidence in the profession and the dental regulator if a finding of impairment were not made.

Sanction

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

340. The Committee considered the mitigating and aggravating factors in this case as outlined in the GDC's guidance at paragraphs 5.17 and 5.18.

341. The Committee considered that there were no mitigating factors in this case, although it acknowledged that Ms Horri had offered to correct the bad dentistry in Patient B's case.

342. The aggravating factors in this case included the following:

- actual harm and risk of harm to patients;
- the involvement of a vulnerable patient – Patient A, who was pregnant at the time, was left unsupervised during treatment;
- misconduct sustained and repeated over a period of time;
- blatant or wilful disregard of the role of the GDC and the systems regulating the profession;
- lack of insight.

343. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not protect the public or satisfy the public interest given the serious nature of the misconduct.

344. The Committee then considered the available sanctions in ascending order starting with the least serious.

345. The Committee concluded that misconduct of this nature cannot be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum. The likelihood of the misconduct being repeated also means that patients and the public interest would not be sufficiently protected by the imposition of such a sanction. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

346. The Committee considered whether a conditions of practice order would be appropriate. However, the Committee considered that this would not appropriate or workable given Ms Horri's minimal engagement with these proceedings and the persistent lack of insight she has shown into her misconduct. The Committee also considered the serious nature of the misconduct, which included permanent harm being caused to two patients and a failure to comply with legal CQC requirements, and concluded that imposing conditions on Ms Horri's practice would not be sufficient or proportionate to maintain public confidence in the profession.

347. The Committee next considered whether to suspend Ms Horri's registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances of the misconduct that it has found. In reaching its decision, the Committee considered that Ms Horri has provided no evidence of remediation, shown no insight into her misconduct or meaningfully engaged with these proceedings. The

Committee also considered the wide-ranging and multiple breaches of the GDC's Standards committed by Ms Horri. She had caused permanent harm to two patients and had left a vulnerable patient unsupervised during treatment. Furthermore, she has not fully engaged with the GDC's investigation and demonstrated unprofessional behavior towards Patient B by threatening her with legal action in response to Patient B's complaint. In particular, the Committee considered Ms Horri's failure to comply with her legal requirements with the CQC to be particularly serious.

348. The Committee, therefore, concluded that a sanction of suspension would not be sufficient to mark the seriousness of Ms Horri's misconduct in this case. Furthermore, the Committee concluded that the suspension of Ms Horri's registration would not be sufficient to maintain the public's confidence in the dental profession.

349. In considering whether the sanction of erasure was appropriate, the Committee had regard to paragraph 6.34 of the *GDC's Guidance*, which states:

'Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or others has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*

…

- *a persistent lack of insight into the seriousness of actions or their consequences.'*

350. It was the view of the Committee that all of the above applied in the circumstances of this case. The Committee concluded that Ms Horri's misconduct was so serious that it was fundamentally incompatible with being a dental professional.

351. In all the circumstances, the Committee has determined to erase Ms Horri's name from the Dentists' Register.

352. The Committee will now consider whether an immediate order should be imposed on Ms Horri's registration, pending the taking effect of its determination for erasure.

Decision on Immediate Order – 13 February 2026

353. The Committee has considered whether to make an order for the immediate suspension of Ms Horri's registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

354. Mr Soliman, on behalf of the GDC, confirmed that he would not be making an application for an immediate order for the same reason as set out in his Stage 2 submissions, which was that it would not be necessary given the current suspension imposed on Ms Horri's other case.

355. The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.

356. The Committee noted Mr Soliman's submission. However, it also noted that it would be open to a Committee in Ms Horri's other case to revoke the substantive order of suspension, imposed for 12 months in November 2025, if it found at the review hearing that she had remedied the concerns and her fitness to practise was no longer impaired. If that were to be the case and no immediate order is imposed at this hearing, there may be a period when Ms Horri would have no restrictions on her registration in the event she appeals the erasure decision.

357. The Committee also concluded that, given the nature of its findings and its reasons for the substantive order of erasure in Ms Horri's case it is necessary to direct that an immediate order of suspension be imposed on the grounds of public protection and in the public interest. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a risk to public safety and public confidence in the profession would be undermined.

358. The Committee determined, therefore, that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest.

359. The effect of this direction is that Ms Horri's registration will be suspended immediately. Unless Ms Horri exercises her right of appeal, the substantive order of erasure will come into effect 28 days from the date on which notice of this decision is deemed to have been served on her. Should Ms Horri exercise her right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

360. The Committee also directs that the interim order currently in place on Ms Horri's registration should be revoked.

361. That concludes this hearing.