Dental Professionals Hearings Service

PUBLIC DETERMINATION

PRIVATE (IN PART) HEARING

Professional Conduct Committee
Initial Hearing

3 - 6 March 2025

Name:	AZAM, Zeeshan
Registration number:	229829
Case number:	CAS-204867-P6L5W6

General Dental Council:	Tom Stevens, Counsel. Instructed by Terry Symon, IHLPS
Registrant:	Present Represented by Jennifer Agyekum, Counsel. Instructed by Clyde & Co Solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Conditions imposed (with a review)
Duration:	12 months
Immediate order:	Immediate conditions of practice order

Committee members:	Diane Meikle	(Lay) (Chair)
	Amita Janda-Dhami	(Dentist)
	Laura Owen	(Dental Care Professional)
Legal adviser:	Megan Ashworth	
Committee Secretary:	Andrew Keeling	

CHARGE

Zeeshan AZAM, a dentist, BDS University of Plymouth 2012 is summoned to appear before the Professional Conduct Committee on 3 March 2025 for an inquiry into the following charge:

"That, being a registered dentist:

1. *You failed to provide an adequate standard of care to Patient 1 on 15 March 2023, in that you incorrectly extracted their UL3.*

2. *You failed to notify the GDC of a complaint made against you on 23 June 2023, within 7 days of this complaint being made.*

3. *Your conduct in Charge 2. was:*

    a. *In breach of condition 6 of your GDC undertakings;*
    b. *misleading,*
    c. *lacking integrity;*
    d. *dishonest, in that you knew you were required to notify the GDC of a complaint made against you within 7 days of it being made.*

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

Mr Azam,

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. You attended the hearing and were represented by Miss Jennifer Agyekum, Counsel. Mr Tom Stevens, Counsel, presented the General Dental Council's (GDC) case. The hearing took place in person at the hearing suite of the Dental Professionals Hearing Service in Wimpole Street, London, between 3 and 6 March 2025.

Preliminary Matter: Rule 18 Application to Amend the Charge (3 March 2025)

2. At the outset of the hearing, Mr Stevens made an application under Rule 18 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") to withdraw head of charge 3(a).

3. Mr Stevens informed the Committee that it is the GDC's case that an oral complaint had been made to you on 23 June 2023 in respect of your incorrect extraction of Patient 1's UL3 at an appointment on 15 March 2023. Mr Stevens submitted that, at the time of the complaint you were the subject of GDC undertakings imposed by the case examiners on your registration in respect of another matter. One of these undertakings was that you were required to inform the GDC of any complaint made against you within seven days, i.e. by 30 June 2023 in respect of this oral complaint.

4. Mr Stevens submitted that the GDC's case examiners had reviewed and revoked the undertakings on your registration on 29 June 2023 with immediate effect. He submitted, therefore, that you could not have been in breach of undertakings that were no longer operative on 30 June 2023.

5. Miss Agyekum, on your behalf, submitted that she had no objection to the application.

The Committee's decision on the Rule 18 application

6. The Committee accepted the advice of the Legal Adviser on the Rule 18 application. The Committee noted and accepted that the undertakings on your registration had been revoked on 29 June 2023 and, therefore it was not a breach of that undertaking not to disclose the complaint to the GDC by 30 June 2023. It also took account of the fact that there was no objection to the application. It was therefore satisfied that the amendment could be made without injustice to either party and that head of charge 3(a) should be withdrawn.

7. The Committee, therefore, acceded to Mr Stevens' application to amend the charge.

Your Admissions

8. Miss Agyekum, on your behalf, informed the Committee that you admitted head of charge 1. She stated that you denied the remaining heads of charge.

Decision on Admissions (3 March 2025)

9. The Committee noted your admission and in line with the GDC's *'Guidance on Admissions made at the Preliminary Stage in Fitness to Practise Proceedings'* (issued in October 2022) announced head of charge 1 as found proved.

Background

10. There are two aspects to the case. The first is a clinical concern in respect of an appointment on 15 March 2023 with Patient 1. You have now formally admitted that you incorrectly extracted Patient 1's UL3, instead of the UL4, and this has been found proved by the Committee.

11. The further allegations in this case flow from your alleged failure to disclose a complaint to the GDC in respect of this extraction. The erroneous extraction was on 15 March 2023 and there was a follow-up appointment on 27 March 202, when you met with Patient 1 and his mother and the erroneous extraction was discussed.

12. At the material time you were subject to undertakings on your registration with the GDC. The Committee was referred to the witness statement dated 18 October 2024 from Elizabeth Barlow, a GDC caseworker, which set out the relevant information regarding the undertakings. These undertakings were effective from 29 March 2022 for a period of 18 months and were subject to periodic review by the GDC's case examiners. One of the undertakings was that you were required to disclose any complaints made against you within seven days of the complaint being made. The undertakings were revoked on 29 June 2023 and you were informed of this on 3 July 2023. On 4 July 2023, you informed the GDC of a written complaint from Patient 1's mother made on 26 June 2023 and received by the practice on 30 June 2023.

13. The GDC's case is that a verbal complaint had been made to you by Patient 1 and his family at the appointment with you on 23 June 2023 regarding the incorrect extraction of Patient 1's UL3. The Committee was referred to your note of the appointment in Patient 1's records and the witness statement of your dental nurse, Witness 1, dated 14 November 2024. The GDC's case is that when considering this evidence, it is clear that a verbal complaint had been made at the appointment of 23 June 2023 as there had been clear dissatisfaction expressed by Patient 1's family about the treatment you had provided. Therefore, this should have been disclosed to the GDC. The wording of undertaking 6 was that you were under a requirement to notify the GDC of any complaint, and that this was not limited to the source or type of the complaint. That complaint was subsequently made in writing by Patient 1 and was dated 26 June 2023, but it was not received by you at the practice until 30 June 2023.

14. The GDC sent you a letter on 17 May 2023, informing you that the undertakings were to be reviewed but you were expected to comply with them until *'such time as the case examiners notified you of their decision'*. On 29 June 2023, the case examiners revoked the undertakings.

Submissions

15. Mr Stevens acknowledged, as set out in his application to withdraw head of charge 3(a), that your failure to disclose the complaint made on 23 June 2023 did not amount to a breach of your undertakings as they were formally revoked on 29 June 2023. However, Mr Stevens submitted that you were still under a professional obligation to disclose the verbal complaint received on 23 June 2023 to the GDC within seven days and adhere to your undertakings as you would not have been aware at the time that they had been revoked. He further submitted that you were not made aware of the revocation of the undertakings by the GDC until you received their letter on 3 July 2023.

16. Mr Stevens submitted that this alleged failure amounted to misleading and dishonest behaviour, and that it was lacking in integrity. In respect of dishonesty, he submitted that it was more likely than not that you would have believed that you should have disclosed the complaint to the GDC by 30 June 2023. Mr Stevens submitted that you knew your undertakings were under review and you were made aware in the letter of 17 May 2023 of the ramifications of the review. Mr Stevens submitted that this was significant and that the most likely reason for your non-disclosure is concealment and therefore is dishonest. You subsequently disclosed the complaint to the GDC on 4 July 2023. However, Mr Stevens submitted that you only disclosed the complaint once you knew the existing case against you had been closed and therefore you could do so without any jeopardy.

17. In respect of lacking in integrity, Mr Stevens submitted that this was separate to dishonesty in that it relates to the ethical standards of one's profession. He submitted that it is alleged that your conduct lacked integrity as you did not take any steps to clarify with the GDC whether this verbal complaint needed to be disclosed.

18. Miss Agyekum submitted that the oral expression of dissatisfaction on 23 June 2023 did not amount to a *'notifiable complaint'* that was required to be disclosed to the GDC. In respect of misleading, she submitted that even if the disclosure was not within the required timescale, it was within four days of when it should have been disclosed and you provided full details to the GDC. Therefore, the GDC was not misled. In respect of lack of integrity, she submitted that you had believed the complaint was received on 30 June 2023 and there was no breach of the ethical codes and therefore no lack of integrity on your part. In respect of dishonesty, she submitted that at worst, the information was received after a four day delay and there was no concealment and therefore no dishonesty. She submitted that the disclosure would not be without

jeopardy because you knew that you may be a subject to an investigation into the wrongful extraction of the tooth.

Evidence

19. By way of factual evidence from the GDC, the Committee was provided with the following signed witness statements:

- Elizabeth Barlow, GDC Caseworker, dated 18 October 2024;
- Witness 1, Dental Nurse, dated 14 November 2024; and
- Patient 1's mother, dated 30 October 2024.

20. The Committee also received a copy of Patient 1's dental records, including correspondence, and an expert report, dated 30 October 2024, from Mr Edward Bateman. All of the documentary evidence was agreed by you, and therefore there was no need for any of the witnesses to attend the hearing to give evidence.

21. As part of your case, the Committee was provided with your signed witness statement, dated 20 January 2025. The Committee also heard oral evidence from you.

The Committee's Findings of Fact (4 March 2025)

22. The Committee has considered all the documentary evidence presented to it. It took account of the submissions made by Mr Stevens, on behalf of the GDC, and by Miss Agyekum, on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has 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 matters are found proved on the balance of probabilities.

23. The Committee's findings in relation to each head of charge are as follows:

1.	You failed to provide an adequate standard of care to Patient 1 on 15 March 2023, in that you incorrectly extracted their UL3. **Admitted and Found Proved**
2.	You failed to notify the GDC of a complaint made against you on 23 June 2023, within 7 days of this complaint being made. **Not Admitted** **Found Proved**

When considering this head of charge, the Committee first sought to determine whether there was a complaint made against you at the appointment with Patient 1 on 23 June 2023.

The Committee accepted Mr Stevens' submissions on the ordinary English definition of a complaint, which is that it is the expression of dissatisfaction or that something is unacceptable.

The Committee reviewed your contemporaneous dental records from the appointment on 23 June 2023. It noted that Patient 1 and his family had clearly expressed their unhappiness and dissatisfaction regarding your extraction of the incorrect tooth. It noted the following entries:

'- brother spoke on behalf, expressed very unhappy about what happened
- brother very disappointed that wrong tooth was removed
- patient expresses he hasn't felt the same since, and that affecting him…'

In particular, the Committee noted that Patient 1's family had now raised the prospect of financial compensation:

- *'Pt/brother seeking compensation – asked what would be right for them*
- *they expressed some financial compensation… '*

The Committee determined that although it was not specifically mentioned in the records that Patient 1 was making a complaint, it was clear by the fact that financial compensation was now being raised, that the family was expressing dissatisfaction about his treatment.

This evidence was supported by Witness 1's witness statement, dated 14 November 2024. Witness 1 was the Dental Nurse who was present at the appointment on 23 June 2023. The Committee noted the following from the statement:

'The patient's older brother said that he wanted to speak to the Registrant personally and express how he felt on behalf of his younger brother. The older brother was very upset, angry, frustrated…The patient and his older brother wanted to seek financial compensation…'

In your oral evidence, you had also accepted that in hindsight that this amounted to a complaint about the treatment you had provided. Although, you stated that you did not believe it was a complaint at the time.

The Committee determined that it was clear from the evidence above, that Patient 1 and his family were expressing dissatisfaction about the treatment on

	15 March 2023, which included a request for financial compensation, and that factually this did amount to a complaint being made. The Committee next considered whether you were under a duty to notify the GDC of that complaint within seven days, i.e. by 30 June 2023. The Committee noted that you were subject to undertakings until 29 June 2023, which included: *'6. He must inform the GDC within 7 days of any complaints made against him from the date these undertakings take effect.'* It was submitted by Miss Agyekum, on your behalf, that you were not under a duty to disclose the complaint to the GDC as the undertakings on your registration were formally revoked on 29 June 2023, i.e. one day before the deadline to disclose. The Committee, however, did not accept this submission. The Committee noted that you were not aware that the undertakings had been revoked until you had received the GDC's letter on 3 July 2023 informing you of this. The Committee also noted the GDC's letter to you dated, 17 May 2023, in which it was stated: *'You are expected to continue to comply with your undertakings until such time as the Case Examiners notify you of their decision.'* The Committee determined, therefore, that you were still under a duty to disclose the complaint to the GDC within seven days, which would have been by 30 June 2023, and you had failed to do so. Accordingly, the Committee found this head of charge proved.
3.	Your conduct in Charge 2. was:
	a. Charge Withdrawn
	b. Misleading **Not Admitted** **Found Proved** The Committee noted that as there is a separate charge against you in respect of dishonesty, it was not required to determine whether your actions were

	intentionally misleading. The question for the Committee was whether, objectively, your actions were misleading. The Committee determined that by your failure to disclose to the GDC the complaint made by Patient 1 on 23 June 2023, the GDC had been misled into believing that there had been no complaints made against you during the material time, albeit it may not have been your intention to mislead the GDC. Accordingly, the Committee found this head of charge proved.
	c. lacking integrity; **Not Admitted** **Found Not Proved** Before considering whether your conduct lacked integrity, the Committee first determined whether your conduct was dishonest. The Committee has accepted (see its reasoning below) that you genuinely believed on 23 June 2023 that Patient 1 had not made a complaint at that appointment, and therefore your conduct was not dishonest. It further noted that you notified the GDC of the complaint on 4 July 2023, which was within seven days of 30 June 2023, the date you received the complaint in writing. You had also apologised to Patient 1 and sought to resolve the matter as quickly as possible by seeking advice from your practice principal. The Committee was satisfied, therefore, that your conduct was not lacking integrity. Accordingly, the Committee found this head of charge not proved.
	d. dishonest, in that you knew you were required to notify the GDC of a complaint made against you within 7 days of it being made. **Not Admitted** **Found Not Proved** When considering this charge, the Committee referred to the test set out in the case of *Ivey v Genting Casinos (UK) Ltd. t/a Crockfords* [2017] *UKSC 67*. It first considered the actual state of your knowledge or belief as to the facts at the time. The Committee then considered whether your conduct would be viewed as dishonest by the objective standards of ordinary and decent people.

	You denied this head of charge. You stated that at the time of the appointment, you did not consider that Patient 1 and his family were making a complaint, which was required to be disclosed to the GDC as it was not in writing at that point. In oral evidence, you stated that when the prospect of financial compensation was raised, you informed Patient 1 and his family that you would need to pause the discussions and seek the advice of your practice principal. You stated that once Patient 1 expressed their dissatisfaction and unhappiness about their treatment in written form, which you received on 30 June 2023, you considered it to be a complaint, which was required to be disclosed to the GDC. The Committee carefully considered your oral evidence and found it to be honest and reliable. It noted from the patient's records that the appointment on 23 June 2023 was booked as an examination rather than a discussion about Patient 1's previous treatment, and following the discussions you carried out an examination. The Committee noted that this note was made contemporaneously and there was no mention that Patient 1 was making a complaint, albeit you recorded that he was dissatisfied with the treatment received on 15 March 2023. The Committee further noted that the meeting with the practice principal took place on 26 June 2023, and therefore the Committee considered that there was no undue delay on your part in seeking a resolution to the concerns. It was agreed at this meeting, that Patient 1 should submit a written complaint and this was received at the practice on 30 June 2023. Once this was received, you disclosed the complaint to the GDC on 4 July 2023 and informed your indemnity providers. Similarly, the Committee noted the email from your practice principal to the GDC, dated 4 July 2023, in which he stated that he received a written complaint, dated 26 June 2023, on 30 June 2023. There was no mention in this email of a complaint having been made at the appointment on 23 June 2023. Taking all this into consideration, therefore, the Committee accepted that you genuinely did not believe on 23 June 2023 that Patient 1 was making a complaint at that appointment, which was required to be disclosed. The Committee accepted your evidence that you only considered it to be a complaint, once it had been put in writing. You then acted accordingly in disclosing it to the GDC and your indemnity provider. The Committee also determined that your conduct would not be viewed as dishonest by the objective standards of ordinary and decent people. Accordingly, the Committee found this head of charge not proved.

24. We now move to Stage 2.

Stage 2

25. Having announced its decision at Stage 1, the Committee then went on to consider whether the facts found proved amounted to misconduct and, if so, whether your fitness to practise is currently impaired by reason of your misconduct, and if so, what sanction, if any, should be imposed. In accordance with Rule 20 of the *GDC (Fitness to Practise) Rules Order of Council 2006* ('the Rules'), the Committee heard submissions from Mr Stevens, on behalf of the GDC, and Miss Agyekum, on your behalf, in relation to the matters of misconduct, impairment and sanction.

Summary of the Committee's Findings of Fact

26. The Committee has found proved, following your admission, that you failed to provide an adequate standard of care to Patient 1 on 15 March 2023 in that you incorrectly extracted their UL3. It also found that you failed to notify the GDC of a complaint made against you by Patient 1's family on 23 June 2023, in respect of this erroneous extraction, within seven days of this complaint being made. This was a requirement specified in the undertakings that you were subject to at the time. The Committee found this conduct to be misleading, albeit not intentionally, as the GDC had been misled into believing that a complaint had not been made when this was not the case. However, the Committee did not find your conduct to be lacking integrity or dishonest.

Document

27. The Committee had regard to a further document at this stage, namely your Stage 2 defence bundle. This contained your witness statement, dated 5 March 2025, with exhibited documents evidencing the remediation you have undertaken, your reflections and a witness statement, dated 16 January 2025, from your current workplace supervisor.

Application for the Hearing to take place in Private

28. Miss Agyekum made an application for the hearing to take place partly in private pursuant to Rule 53. She submitted that you were due to give oral evidence at this stage and that you will be touching upon matters in respect of your private life, including your health. She submitted that the hearing should go into private session when these matters are discussed. Mr Stevens did not object to this application.

29. The Committee heard and accepted the advice of the Legal Adviser as to the provisions of the Rules and the approach it should take to its decision.

30. The Committee bore in mind that, as a starting point, hearings should be conducted in public session. However, the Committee was satisfied that the hearing should be heard in private as and when matters of your private life and health are to be discussed. The Committee was satisfied that this outweighed the public interest in open hearings. It therefore acceded to the application.

Oral Evidence

31. You gave oral evidence and answered questions from Miss Agyekum. You explained the changes you had made to your practice and the Continuing Professional Development (CPD) courses you had undertaken following the extraction incident in March 2023. These changes included seeking further assistance from your dental nurse during the extraction procedure and putting a protocol in place each time an extraction was due to be carried out.

32. You then explained the impact upon you of a second incident in which you had extracted the wrong tooth, which took place on 5 July 2024. You explained that this had hit you quite hard, especially as it had happened following the changes you had made to your practice following the first incorrect extraction. Following this second incident, you stated that you initially stopped doing extractions altogether. Then you went back to basics, observed other dentists extracting teeth and arranged for an observership at an Intermediate Minor Oral Surgery (IMOS) clinic. You also instigated more changes in your practice, which included undertaking the extraction standing up rather than sitting down to help with your concentration, only using one instrument for the procedure, developing a checklist and marking the tooth that needed extracting. You explained that these changes eventually restored your lost confidence. You stated that you have also kept a log of extractions you have undertaken from September 2024 to February 2025 and there have been no further incidents.

33. In addition to the above, you explained the impact that certain events in your private life had had on you around the time of the first extraction. However, you stated that these have now been resolved.

Submissions

34. Mr Stevens, on behalf of the GDC, first addressed the Committee on your fitness to practise history, as required under Rule 20(1)(a). He submitted that, as the Committee would already be aware from the documents in this case, you were subject to undertakings between 2021 and 2023. He informed the Committee that this related to concerns raised about your clinical practice between 2016 and 2019. However, none of these concerns involved extractions.

35. Mr Stevens also informed the Committee that following a PCC hearing in March 2024, your fitness to practise was found to be impaired by reason of conviction and misconduct. He submitted that your conviction related to driving matters from 2019 and

the misconduct related to your failure to disclose the conviction to the GDC. That Committee further found that your failure to disclose was objectively misleading, but not dishonest.

36. Mr Stevens also informed the Committee that you are currently being investigated by the GDC in respect of an incorrect extraction of a tooth in July 2024. He submitted that the GDC's investigation into this was ongoing and no findings have yet been made. Furthermore, he submitted that you have accepted that you undertook an incorrect extraction and that you spoke about it in your oral evidence at Stage 2 of this hearing. Furthermore, you self- referred the matter to the GDC. He submitted, therefore, it would be a matter for the Committee as to the significance it places on this incident during its deliberations at this stage.

37. Mr Stevens then addressed the Committee on the matter of misconduct. Firstly, in respect of the clinical matter, he submitted that this was a very serious clinical failing, which had caused actual harm, both physical and psychological, to Patient 1. He referred the Committee to Mr Bateman's expert report, which stated that your actions fell far below the standards expected of a competent dentist. Mr Stevens submitted, therefore, that this comfortably passed the threshold for misconduct. In respect of your misleading behaviour, Mr Stevens submitted that he would be making no positive submissions as to whether it constituted impairment. He referred the Committee to the PCC's finding of impairment in March 2024 as relevant context, but submitted that it would be a matter for the Committee as to how much weight it should attach to it.

38. Mr Stevens next addressed the Committee on the matter of impairment. He submitted that the GDC acknowledges that the clinical failing relates to a discrete aspect of your clinical practice and therefore it was capable of being remedied. However, he invited the Committee to conclude that your fitness to practise is currently impaired by reason of your misconduct. He acknowledged all of the remediation work you have undertaken. However, he submitted that it was significant that even after the remediation work you had undertaken following the first incorrect extraction, a second incorrect extraction occurred on July 2024. He submitted that this was an important consideration in assessing current risk. Since the second extraction, he submitted that it was right to acknowledge the further remediation you have undertaken. However, he submitted that this remediation was not sufficiently embedded in your clinical practice to enable the Committee to conclude that you currently posed no risk to the public. Furthermore, he submitted that such is the seriousness of the clinical failing, a finding of impairment was also required in the wider public interest.

39. In respect of sanction, Mr Stevens submitted that the most appropriate and proportionate sanction would be one of conditions for 18 months with a review hearing.

40. Miss Agyekum, on your behalf, submitted that in respect of misconduct, the Committee should keep in mind that this was a single clinical incident. In respect of your misleading behaviour, she submitted that this did not meet the threshold of seriousness to be considered misconduct.

41. In respect of impairment, Miss Agyekum submitted that following the incorrect extractions, you had fully reflected on both incidents, had identified what went wrong, why it went wrong and the effect it had had on the patients and the profession. She submitted that you have made changes to your practice and undergone targeted CPD. You have also undergone retraining and gone back to basics in respect of your clinical practice. You have also sought to identify and address the external factors that had an impact on your practice. She referred the Committee to the log of over 60 extractions you have undertaken since the second incorrect extraction, which have occurred without incident.

42. Miss Agyekum submitted that these improvements have now been embedded in your clinical practice and your insight into your conduct is also complete. She submitted, therefore, that the clinical failing was highly unlikely to be repeated. She referred the Committee to the witness statement of your workplace supervisor, who stated that your colleagues and patients have no reservations about your practice. She submitted, therefore, that a finding of current impairment for your clinical failing was not required for public protection. Further, she submitted that a finding of impairment was not required for your misleading conduct as this has been fully remedied and was unlikely to be repeated.

43. Miss Agyekum submitted that it was also not necessary for a finding of current impairment in the wider public interest. She submitted that a well-informed member of the public would be satisfied that your conduct had been sufficiently marked by these proceedings taking place. Furthermore, she submitted that it was in the public interest in allowing a well-skilled dental practitioner to continue to practise without restriction.

44. In respect of sanction, Miss Agyekum submitted that anything greater than a reprimand would be disproportionate and unnecessary.

Committee's Decision (6 March 2025)

45. 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 and had regard to the relevant case law. The Committee first considered whether the facts found proved amounted to misconduct.

Misconduct

46. The Committee had regard to the GDC's *Standards for the Dental Team (2013)* (the GDC Standards) and determined that you had breached the following sections in particular:

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

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

47. In respect of your extraction of the wrong tooth, the Committee considered that this was a serious clinical failing which had resulted in actual harm suffered by Patient 1. It also had regard to the witness statement from Patient 1's mother, dated 30 October 2024, and noted the psychological harm it had caused Patient 1. The Committee further noted and accepted the conclusion in Mr Bateman's expert report that your conduct fell far below the standards expected of a competent general dental practitioner.

48. The Committee determined, therefore, that this clinical failing was sufficiently serious to amount to a finding of misconduct.

49. In respect of your misleading behaviour, the Committee noted that this was not intentional. It had not found that your conduct was either dishonest or lacking in integrity, rather it had accepted that you had genuinely believed that the expression of dissatisfaction by Patient 1 and his family at the appointment on 23 June 2023 did not amount to a complaint which required disclosing to the GDC. The Committee also noted the finding of misleading by the PCC in March 2024, but noted that that PCC had similarly found that your conduct was not intentional.

50. The Committee, therefore, determined that your misleading behaviour was not sufficiently serious to amount to a finding of misconduct.

Impairment

51. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct.

52. The Committee first noted that as your misconduct involved a discrete area of your clinical practice it was remediable. It then went on to consider whether it had been remedied. The Committee took into consideration all of your remediation evidence. This included the CPD courses you had undertaken, the clinical observership you had undertaken at the IMOS clinic, your Personal Development Plan (PDP), audits undertaken, patient satisfaction feedback and positive testimonials.

53. The Committee also considered your oral evidence and written reflections. It noted the changes you had implemented in your clinical practice to prevent a reoccurrence of an incorrect extraction. Furthermore, it was clear to the Committee that you had reflected deeply about the reasons the clinical failing occurred and the impact it has had on patients and the dental profession. The Committee considered that your insight into your clinical failing was well developed.

54. However, despite the remediation work you have undertaken and the insight you have shown, the Committee considered that it was significant that a similar incident occurred in July 2024. The Committee noted that this is currently being investigated by the GDC and no adverse findings have been made against you. However, it noted from your oral and written evidence that you appeared to accept the clinical failing and have made further changes to your practice to ensure that it is not repeated. The Committee noted the log of extractions you have undertaken between 3 September 2024 and 27 February 2025 and there have been no further incidents. However, the Committee was not satisfied that your remediation and learning had been fully embedded into your clinical practice. The Committee noted that the first incorrect extraction was a serious clinical failing and this was followed by a second incident which occurred only eight months ago whilst you were subject to interim order conditions on your registration, including close supervision of your practice. Therefore, the Committee determined that there was a still a risk of repetition of the clinical failing which would impact on public safety.

55. Accordingly, the Committee determined that a finding of impairment is necessary in the interests of public protection.

56. The Committee also determined that a finding of impairment is necessary in the wider public interest to maintain public confidence and uphold proper standards of conduct and behaviour. Your actions fell far below the required standard and resulted in actual physical and psychological harm to Patient 1. The Committee concluded that a reasonable and informed member of the public, fully aware of the facts of the case, would lose confidence in the profession and the dental regulator if a finding of impairment were not made in the circumstances of this case.

57. The Committee therefore determined that your fitness to practise is also currently impaired on the ground of public interest.

Sanction

58. The Committee next considered what sanction, if any, to impose on your 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 your interest with the public interest. It also took into account the *GDC's Guidance*.

59. 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.

60. The mitigating factors in this case include:

- Evidence of remedial action taken following the incident (although this has not yet been fully embedded into your clinical practice);
- Evidence of remorse shown, insight and an apology given;

61. The aggravating factor in this case include actual harm being caused to a patient.

62. Taking all these factors into account, the Committee considered the available sanctions, starting with the least restrictive. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration. However, it concluded that taking no action would not be appropriate or proportionate, given the seriousness of its findings and the identified concerns about public protection and the public interest.

63. The Committee next considered whether to issue you with a reprimand. It had regard to paragraph 6.7 of the GDC's Guidance which states, *"A reprimand is the lowest sanction which can be applied and may therefore be appropriate where the misconduct … is at the lower end of the spectrum. A reprimand does not impose requirements on a registrant's practice and should therefore only be used in cases where he or she is fit to continue practising without restrictions. A reprimand might be appropriate if the circumstances do not pose a risk to patients or the public which requires rehabilitation or restriction of practice."* The Committee concluded that your misconduct was serious, and the Committee has identified a risk of repetition. Accordingly, the Committee determined that issuing a reprimand would not be sufficient to protect the public.

64. The Committee went on to consider whether to impose conditions on your registration. It noted in the GDC's Guidance that conditions may be appropriate when '*there are discrete aspects of the Registrant's practice that are problematic*'. The Committee noted the remediation you had undertaken but has determined that this has not yet been fully embedded into your clinical practice. The Committee considered, therefore a conditions of practice order would be the most appropriate and suitable way for you to do this whilst also ensuring the public is protected. These conditions would only permit you to undertake tooth extractions whilst directly supervised. You would also be required to maintain a log of any extractions undertaken. The Committee also noted that you have already positively engaged with an interim order of conditions and undertakings on your registration such that the Committee could be confident that you would respond positively to conditions at this time. Taking all of this into account, the Committee was satisfied that conditional registration would be appropriate, proportionate, and sufficient to protect the public.

65. In concluding that a period of conditional registration would be the most appropriate sanction, the Committee had regard to the GDC's Guidance at paragraph 6.28 which deals with the sanction of suspension. Having had regard to the relevant factors in that paragraph, the Committee concluded that the matters in this case had not reached the threshold of seriousness for the suspension of your registration. It also considered that a suspension would be disproportionate, given the steps you have undertaken already to address the concerns raised from this misconduct. The Committee was mindful of its duty to act proportionately and to only impose the level of restriction necessary, which in its view, is conditional registration.

66. In all the circumstances, the Committee has determined to impose conditions on your registration for a period of 12 months. In deciding on this 12-month period, the Committee considered that this would be sufficient time for you to demonstrate that your remediation work has been fully embedded in your practice. The Committee is satisfied that this is the appropriate and proportionate period.

67. The conditions that will appear against your name in the Dentists' Register are as follows:

1. *He must forward a copy of his Personal Development Plan to the GDC within three months of the date on which these conditions become effective.*

2. *He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services [and the Commissioning Body on whose Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland].*

3. *He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and the reporter and workplace supervisor referred to in these conditions.*

4. *At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by him and approved by the GDC. The reporter shall be a GDC registrant.*

5. *He must allow the reporter to provide reports to the GDC at intervals of not more than four months.*

6. *He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.*

7. *He must inform the GDC if he applies for dental employment outside the UK.*

8. *a. He must not carry out tooth extractions unless directly supervised* by a workplace supervisor nominated by him, and agreed by the GDC.*

   b. He must maintain a log detailing every case where he has undertaken a tooth extraction.

   c. He must provide a copy of this log to the GDC on a four monthly basis or, alternatively, confirm that there have been no such cases during that period.

9. *He must allow his workplace supervisor to provide reports to the GDC at intervals of not more than four months and the GDC will make these reports available to any*

Postgraduate Dean/Director or Educational Supervisor referred to in these conditions

10. *He must inform promptly the following parties that his registration is subject to the conditions, listed at (1) to (9), above:*

    - *Any organisation or person employing or contracting with him to undertake dental work;*
    - *Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application);*
    - *Any prospective employer (at the time of application);*
    - *The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application).*

11. *He must permit the GDC to disclose the above conditions, (1) to (10), to any person requesting information about his registration status.*

**__Directly Supervised__: the workplace supervisor must observe the registrant's day-today work, or the particular element(s) of the registrant's work, as prescribed in the relevant condition or undertaking. The workplace supervisor must always be on site and available to directly observe the specified element(s) when the registrant is working. Where the workplace supervisor is unavailable through illness or planned absence, the registrant must not carry out the specified element(s) of their work unless an approved alternative workplace supervisor is in place. Conditions or undertakings will specify which element(s) of a registrant's practice to observe.*

68. The Committee also directs that there be a review of your case. This means that a Committee will review your case at a hearing to be held shortly before the end of this period of conditional registration. That Committee will consider what action to take in relation to your registration. You will be informed of the date and time of that hearing, with which you will be expected to engage.

69. Unless you exercise your right of appeal, the above conditions will take effect 28 days from the date when notice is deemed to have been served upon you. However, the Committee now invites submissions as to whether an immediate order of conditions should be imposed on your registration to cover the appeal period, pending the substantive direction for conditions taking effect.

Decision on Immediate Order (6 March 2025)

70. The Committee has considered whether to make an immediate order of conditions on your registration in accordance with Section 30 of the Dentists Act 1984 (as amended).

71. Mr Stevens, on behalf of the GDC, submitted that such an order is necessary for the protection of the public owing to the risk of repetition of the clinical failing identified by the Committee. He also submitted that an immediate order is otherwise in the public interest as it would undermine public confidence in the profession if an order was not imposed.

72. Miss Agyekum, on your behalf, informed the Committee that she had no submissions to make in respect of an immediate order.

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

74. The Committee is satisfied that an immediate order of conditions is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of conditions in your case including the risk of repetition, it is necessary to direct that an immediate order of conditions be imposed on both of these grounds. 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.

75. The effect of the foregoing determination and this order is that your registration will be subject to the aforementioned conditions immediately from the date on which notice is deemed to have been served upon you. Unless you exercise your right of appeal, the substantive direction for conditional registration as already announced, will take effect 28 days from the date of deemed service, and continue for a period of 12 months. In the event that you exercise your right of appeal, this immediate order will remain in place until resolution of the appeal.

76. The Committee also directs that the interim order currently in place on your registration should be revoked.

77. That concludes this hearing.