

PUBLIC HEARING**Professional Conduct Committee
Initial Hearing****7 – 9 September 2026****Name:** BROWN, Dorothea Elizabeth**Registration number:** 63762**Case number:** CAS-213146-C8C5X3

General Dental Council: Miss Victoria Shehadeh, Counsel.
Instructed by Rosie Geddes, IHLPS**Registrant:** Not Present
Unrepresented

Fitness to practise: Impaired by reason of misconduct**Outcome:** Suspension (with a review)**Duration:** 12 months**Immediate order:** Suspension

Committee members: Andrea Hammond (Dental Care Professional) (Chair)
Amita Janda-Dhami (Dentist)
Kamaljit Sandhu (Lay)**Legal adviser:** Edward Hosking**Committee Secretary:** Andrew Keeling

CHARGE

That being registered as a dentist, between 27 August 2015 and 16 February 2023, you:

- 1. Failed to provide an adequate standard of care to Patient A in respect of radiographic practise in that you did not:*
 - a) Carry out regular bitewing radiographs as part of routine care; and/or*
 - b) Carry out bitewing radiographs once bone loss was apparent on/around 16 February 2023; and/or*
 - c) Did not carry out radiographs to investigate the cause of repeated restoration failure of tooth UL1.*
- 2. Failed to provide an adequate standard of care to Patient A in that you:*
 - a) Did not carry out or record six-point periodontal charting; and/or*
 - b) Did not identify signs of bleeding during routine probing; and/or*
 - c) Did not identify signs of subgingival calculus; and/or*
 - d) Did not identify early signs of pocketing; and/or*
 - e) Did not put in place a treatment plan to prevent serious periodontal disease from developing or worsening; and/or*
 - f) Did not provide appropriate treatment to address the patient's presenting periodontal condition; and/or*
 - g) Did not investigate the causes of repeated restoration failure of tooth UL1.*
- 3. Did not maintain adequate patient records in relation to your appointments with Patient A between 27 August 2015 and 16 February 2023 in that you did not:*
 - a) Distinguish between gingivitis and periodontitis; and/or*
 - b) Include regular Basic Periodontal Examination Scores;*
 - c) Record radiographic assessment and/or justification and/or interpretation;*

d) Record detailed discussions of assessment and/or diagnosis and/or treatment planning;

e) Provide supporting clinical data when recording a diagnosis.

4. Failed to co-operate with the General Dental Council in relation to your treatment of Patient A in that you:

a) Did not respond to the General Dental Council's enquiries from 3 October 2024 onwards; and/or

b) Did not provide complete evidence regarding your indemnity cover.

AND by reason of the above your fitness to practise is impaired by reason of misconduct.

1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegations against Miss Brown that her fitness to practise is impaired by reason of misconduct.
2. Miss Brown was neither present nor represented at the hearing. Miss Victoria Shehadeh, Counsel, appeared on behalf of the General Dental Council (GDC).
3. The hearing was held remotely on Microsoft Teams.

Preliminary Matters

4. The Committee first considered the issues of service and whether to proceed with the hearing in the absence of Miss Brown. The Committee heard submissions from Miss Shehadeh. It 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.

Decision on Service of the Notice of Hearing (7 September 2026)

5. The Committee received from the GDC an indexed hearing bundle of 329 pages, which contained a copy of the Notice of Hearing ('the notice'), dated 3 August 2026, thereby complying with the 28-day notice period. The notice was sent to Miss Brown's registered address by Special Delivery, by first class post and email.
6. The Committee was satisfied that the notice sent to Miss Brown contained proper notification of today's hearing. This included the hearing's time, date and that it will be taking place remotely on Microsoft Teams, and the other prescribed information including notification that the Committee had the power to proceed with the hearing in Miss Brown's absence.

7. On the basis of the information provided, the Committee was satisfied that the notice of the hearing had been served on Miss Brown in accordance with Rules 13 and 65.

Decision on Proceeding in the Registrant's Absence

8. The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Miss Brown. The Committee approached the issue of proceeding in absence 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 Brown and the GDC, taking into account the public interest and Miss Brown's own interests.
9. The Committee noted that the GDC had taken all possible steps to notify Miss Brown of the hearing in accordance with the Rules and the Act. There has been no response from Miss Brown in relation to the notice and there has been no request for an adjournment. The Committee also noted that it appears that Miss Brown has not co-operated fully with the GDC's investigation and this forms part of the charge against her at this hearing. The Committee concluded that Miss Brown has voluntarily absented herself from today's hearing. The Committee further considered that adjourning the hearing would not serve any useful purpose as, given her previous apparent non-engagement, it would be unlikely she would attend any future hearing. Furthermore, the Committee considered that an adjournment would be unfair and inconvenient for the witnesses scheduled to attend.
10. Therefore, having weighed the interests of Miss Brown with those of the GDC and the public interest in an expeditious disposal of this hearing, the Committee has determined that it was fair and in the public interest to proceed in Miss Brown's absence.

Background

11. In her opening submissions to the Committee, Miss Shehadeh outlined the background to the case and summarised the charges against Miss Brown.
12. Miss Shehadeh submitted that the allegations in this case involve Miss Brown's clinical treatment of Patient A and her subsequent alleged failure to co-operate with the GDC's investigation into her fitness to practise, including not providing complete evidence regarding her indemnity cover. In respect of the clinical concerns, she submitted that these can be divided into three areas, namely Miss Brown's radiographic practice, her treatment, diagnosis or otherwise of Patient A's gum disease and her record keeping.
13. Miss Shehadeh informed the Committee that Patient A had been seeing Miss Brown for routine check-ups and dental care since around 2015. In October 2023, Patient A saw a subsequent treating dentist (STD) for tooth-whitening as this was not provided at

Miss Brown's practice. The STD informed Patient A that she had advanced gum disease. Patient A explained that she was taken aback by this news, as this had not been told to her by Miss Brown despite her telling Miss Brown at various times that her gums were bleeding and that the filling on her front tooth kept falling out.

14. Patient A subsequently raised a complaint to the practice about Miss Brown. However, the response she received from the practice was that Miss Brown had provided an acceptable level of care. Miss Brown had acknowledged the complaint after three weeks, but never fully responded to it. Patient A then raised a complaint with the GDC on 17 June 2024.

Evidence

15. By way of factual evidence from the GDC, the Committee was provided with the following signed witness statements and associated exhibits:

- Witness statement, dated 18 April 2026, from Patient A;
- Witness statement, dated 16 April 2026, from Mohammed Iyaz Ausaluth, a Fitness to Practise Caseworker at the GDC

16. As part of the exhibits to the witness statements above, these included copies of Patient A's records from Miss Brown's practice and from the STD.

17. The Committee also received an expert report, dated 29 April 2026, from Mr Salman Malik.

18. The Committee heard oral evidence from Patient A.

The Committee's Findings of Fact

19. The Committee has considered all the documentary evidence presented to it. It took account of the submissions made by Miss Shehadeh, on behalf of the GDC. 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.

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

That being registered as a dentist, between 27 August 2015 and 16 February 2023, you:	
1.	Failed to provide an adequate standard of care to Patient A in respect of radiographic practise in that you did not:

	a) Carry out regular bitewing radiographs as part of routine care; and/or Found Proved When determining this head of charge, the Committee first considered whether there would have been a duty on Miss Brown to carry out bitewing radiographs as part of routine care. The Committee accepted the following evidence from Mr Malik's expert report that there would have been such a duty on Miss Brown: <i>'Radiographic examination is a fundamental component of routine general dental care. In adult patients attending regularly, bitewing radiographs would ordinarily be expected at intervals determined by individual risk assessment, but commonly within a period of up to two years. This expectation is reflected in FGDP Selection Criteria for Dental Radiography, NICE Clinical Guideline CG19 (Dental Recall), and routine teaching within general practice. Bitewings are not solely for caries detection; they are also essential for assessing alveolar bone height and detecting early periodontal breakdown.'</i> The Committee considered Patient A's records and could see no evidence that Miss Brown had taken any bitewing radiographs as part of Patient A's routine care between 2015 and 2023. Accordingly, the Committee found this head of charge proved.
	b) Carry out bitewing radiographs once bone loss was apparent on/around 16 February 2023; and/or Found Proved As noted in its reasoning above, the Committee accepted Mr Malik's evidence that there would have been a duty on Miss Brown to take bitewing radiographs. The Committee considered that this would have been especially apparent at the appointment in February 2023. The Committee noted the following from Mr Malik's report: <i>'In my opinion, at the very latest, radiographs should have been taken at the February 2023 appointment when bone loss was acknowledged in the clinical notes. The failure to do so at that point cannot be justified as a matter of clinical discretion; it represents a failure to undertake essential diagnostic investigation.'</i>

	However, the Committee could see no evidence from Patient A's records that Miss Brown had taken bitewing radiographs at this appointment. Accordingly, the Committee found this head of charge proved.
	c) Did not carry out radiographs to investigate the cause of repeated restoration failure of tooth UL1. Found Proved The Committee accepted the following evidence from Mr Malik's expert report: <i>'The first clear trigger point arises during 2021, when the patient experienced repeated failure of an anterior restoration. Recurrent restoration failure is a recognised indicator that underlying structural or periodontal support should be reassessed. At that stage, radiographic evaluation of supporting bone levels would have been appropriate to exclude periodontal compromise contributing to restorative instability. There is no evidence that such radiographs were taken.'</i> As above, the Committee could see no evidence from Patient A's records that Miss Brown had taken any radiographs throughout her clinical treatment of Patient A. Accordingly, the Committee found this head of charge proved.
2.	Failed to provide an adequate standard of care to Patient A in that you:
	a) Did not carry out or record six-point periodontal charting; and/or As for head of charge 1, the Committee first sought to determine whether there would have been a duty on Miss Brown to carry out six-point periodontal charting. The Committee accepted the following evidence from Mr Malik's report: <i>'BSP Periodontal Guidance</i> <i>BSP guidance recommends routine periodontal screening using the Basic Periodontal Examination (BPE) and escalation to more detailed charting where disease is suspected.'</i>

	The Committee could see no evidence from Patient A's records that Miss Brown had carried out or recorded undertaking six-point periodontal charting during her treatment of Patient A. It also accepted Mr Malik's evidence in his report that, <i>'The records do not demonstrate consistent periodontal screening or escalation to detailed charting where indicated.'</i> Accordingly, the Committee found this head of charge proved.
	b) Did not identify signs of bleeding during routine probing; and/or Found Proved The Committee accepted the evidence in Mr Malik's report that owing to the outcome of the STD's assessment of Patient A, it was apparent that periodontal disease had occurred over time. Therefore, signs of bleeding were more likely to have been present during Miss Brown's treatment of Patient A: <i>'The subsequent treating dentist recorded the presence of periodontal inflammation and calculus accumulation. Subgingival calculus (hardened plaque beneath the gum margin) is a recognised aetiological factor in periodontitis. Subgingival calculus is evident within the bitewing radiographs taken by the subsequent treating dentist. Subgingival calculus contributes to chronic inflammatory response, pocket formation, and progressive attachment loss. Its presence is detectable clinically through probing and tactile assessment.'</i> <i>In a patient attending regularly over a prolonged period, the accumulation of subgingival calculus to the degree later identified would not typically occur without clinical signs. A reasonably competent dentist performing routine periodontal screening would ordinarily detect bleeding on probing, calculus deposits, and early pocketing. Such findings should prompt escalation to detailed charting and structured periodontal therapy.'</i> The Committee could see no specific reference in Patient A's clinical notes that Miss Brown had identified any signs of bleeding on probing. Accordingly, the Committee found this head of charge proved.
	c) Did not identify signs of subgingival calculus; and/or Found Proved

	The Committee noted that the STD had identified subgingival calculus from the bitewing radiographs he had taken and that this would have been present for some time. It accepted the following evidence from Mr Malik's report in this regard: <i>'The subsequent treating dentist recorded the presence of periodontal inflammation and calculus accumulation. Subgingival calculus (hardened plaque beneath the gum margin) is a recognised aetiological factor in periodontitis. Subgingival calculus is evident within the bitewing radiographs taken by the subsequent treating dentist. Subgingival calculus contributes to chronic inflammatory response, pocket formation, and progressive attachment loss. Its presence is detectable clinically through probing and tactile assessment.'</i> The Committee could see no evidence from the clinical records that Miss Brown had identified signs of subgingival calculus during her treatment of Patient A. Furthermore, the Committee accepted Patient A's evidence when she described being shocked when told by the STD that she had periodontal disease, as this had not been mentioned to her by Miss Brown. Accordingly, the Committee found this head of charge proved.
	d) Did not identify early signs of pocketing; and/or Found Proved The Committee noted that the only mention of <i>'pocketing'</i> in Patient A's clinical records was during the appointment on 16 February 2023 when Miss Brown discussed this with Patient A: <i>'Discussed pocketing and gum disease Explained loss of bone, advised pt to come regularly especially if bleeding continues'</i> However, as noted in its reasoning above, the Committee was of the view that Patient A's periodontal disease had taken place over a long period, and therefore it was likely that pocketing would have occurred prior to this appointment. The Committee also bore in mind that Miss Brown had been treating Patient A regularly since 2015 and it could see no evidence from the records that Miss Brown had identified pocketing prior to the appointment in February 2023. The Committee determined, therefore, that it was more likely than not that Miss Brown had not identified the early signs of pocketing.

	Accordingly, the Committee found this head of charge proved.
	e) Did not put in place a treatment plan to prevent serious periodontal disease from developing or worsening; and/or Found Proved The Committee noted and accepted the following from Mr Malik's report that at no point did Miss Brown put in place a treatment plan to prevent serious periodontal disease from developing or worsening: <i>'The records in this case show episodic interventions but do not demonstrate coherent or structured treatment planning. Even after chronic periodontal disease was explicitly recorded in February 2023, there is no documented periodontal treatment plan, no evidence of staged management, and no record of review or maintenance planning. Treatment appears reactive rather than strategic.'</i> Furthermore, the Committee had sight of the treatment plan proposed by the STD in June 2024 for Patient A. The Committee could see no evidence in the records of such a plan put in place by Miss Brown for Patient A. Accordingly, the Committee found this head of charge proved.
	f) Did not provide appropriate treatment to address the patient's presenting periodontal condition; and/or Found Proved In addition to its reasoning above at head of charge 2(e), the Committee determined that without a treatment plan in place to address Patient A's periodontal disease it was more likely than not that she did not provide appropriate treatment. Certainly, the Committee could see no evidence within Patient A's records that any appropriate treatment had been provided to Patient A. Accordingly, the Committee found this head of charge proved.
	g) Did not investigate the causes of repeated restoration failure of tooth UL1. Found Proved

	The Committee noted from the clinical records that there were several occasions in 2021 when Patient A's UL1's restoration failed. However, there was no evidence in the notes that Miss Brown investigated the causes of this failure. The Committee also accepted Mr Malik's evidence in his expert report as follows: <i>'2021 – Repeated anterior restoration failure</i> <i>10. During 2021, the records document repeated failure of a restoration on UL1, with the restoration dislodging and being replaced on more than one occasion.</i> <i>11. One entry records that the "front fill" had come out again and was replaced.</i> <i>12. Repeated restoration failure is usually associated with an underlying issue, namely:</i> <i>o occlusal loading,</i> <i>o parafunction,</i> <i>o or compromised periodontal support.</i> <i>13. There is no contemporaneous evidence that these repeated failures triggered:</i> <i>o reassessment of periodontal health,</i> <i>o radiographic investigation of bone support,</i> <i>o or reconsideration of underlying aetiology.</i> <i>This represents a missed diagnostic opportunity. Repeated failure should prompt investigation, not simply repetition of the same treatment.'</i> Accordingly, the Committee found this head of charge proved.
3.	Did not maintain adequate patient records in relation to your appointments with Patient A between 27 August 2015 and 16 February 2023 in that you did not:
	a) Distinguish between gingivitis and periodontitis; and/or Found Not Proved

As with heads of charge 1 and 2, the Committee first sought to determine whether there was a duty incumbent on Miss Brown to maintain adequate patient records whilst treating Patient A. With reference to the following in Mr Malik's report, the Committee was satisfied that there was such a duty:

'Allegation 2 – Record keeping

90. Professional guidance from the General Dental Council, FGDP (UK) Standards in Dentistry, and Faculty of Dental Surgery record keeping guidance consistently emphasise that records must be accurate, contemporaneous, and sufficiently detailed to reflect clinical decision-making:

91. GDC Standards for the Dental Team (2013)

Standard 4.1 states that dental professionals must:

"Make and keep contemporaneous, complete and accurate patient records."

The Committee noted from the clinical records that Miss Brown had made reference to gingivitis (in bold below) in respect of Patient A's appointments on 28 April 2016 and 6 December 2018:

<i>'28/04/16 DB</i>	<i>EXAM, Examination 19.70</i> <i>Medical history updated</i> <i>Extra-Oral Tissues NAD</i> <i>TMJ NAD</i> <i>Soft Tissues NAD</i> <i>1 1 1 Periodontal Diagnosis</i> <i>1 1 1 Gingivitis'</i>
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<i>'06/12/18 DB</i>	<i>EXAM, Examination</i> <i>Medical history updated</i> <i>Extra-Oral Tissues NAD</i> <i>TMJ NAD</i> <i>Soft Tissues NAD</i> <i>Teeth Checked</i> <i>1 0 1 Periodontal Diagnosis</i> <i>1 1 1 Gingivitis'</i>
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The Committee further noted that there is subsequent reference in the records to '*periodontitis*' in respect of an appointment on 16 February 2023:

	<i>'16/02/23 DB</i> <i>EXAM, Examination</i> <i>Medical history updated</i> <i>Extra-Oral Tissues NAD</i> <i>TMJ NAD</i> <i>Soft Tissues NAD</i> <i>Teeth Checked</i> <i>2 0 2 Periodontal Diagnosis</i> <i>2 1 2 Chronic Periodontal Disease'</i> The Committee considered therefore that Miss Brown had specifically referenced on three separate occasions that Patient A had either gingivitis or periodontitis. The Committee was mindful that Miss Brown had not given reasons for her diagnoses, but it was satisfied that this amounted to sufficient evidence that she had distinguished between both of them. Therefore, in light of these references within the records, the Committee was not satisfied that the GDC had provided sufficient evidence to prove this charge to the required standard. Accordingly, the Committee found this head of charge not proved.
	b) Include regular Basic Periodontal Examination Scores; Found Proved The Committee noted from Patient A's records that Miss Brown had regularly recorded Basic Periodontal Examination (BPE) scores between 2015 and 2018. However, after 2018, the Committee noted that the next BPE score was recorded in 2023. Therefore, the Committee determined that throughout Miss Brown's treatment of Patient A from 2015 to 2023, regular BPE scores were not recorded. Accordingly, the Committee found this head of charge proved.
	c) Record radiographic assessment and/or justification and/or interpretation; Found Proved

	The Committee has found proved at head of charge 1 that Miss Brown had failed to take any radiographs whilst treating Patient A. Therefore, it follows, that Miss Brown did not make any records in this regard. The Committee also noted there was no record or justification for not taking any radiographs. Accordingly, the Committee found this head of charge proved.
	d) Record detailed discussions of assessment and/or diagnosis and/or treatment planning; Found Proved The Committee noted that there was no evidence within the clinical records that Miss Brown had recorded detailed discussions of assessment and/or diagnosis and/or treatment planning. In particular, the Committee noted that this was absent when Patient A had attended when her UL1 restoration had failed and when periodontal disease was identified. Furthermore, Patient A could not recall any such discussions taking place. Accordingly, the Committee found this head of charge proved.
	e) Provide supporting clinical data when recording a diagnosis. Found Proved The Committee noted that at the times when Miss Brown had made diagnoses of gingivitis and periodontitis, there was no supporting clinical data provided to show how she came to these conclusions. Accordingly, the Committee found this head of charge proved.
4.	Failed to co-operate with the General Dental Council in relation to your treatment of Patient A in that you:
	1. Did not respond to the General Dental Council's enquiries from 3 October 2024 onwards; and/or Found Proved

	Firstly, the Committee was satisfied that Miss Brown had a duty to comply with any investigation by the GDC as outlined in the GDC's Standards for the Dental Team: <i>9.4 You must co-operate with any relevant formal or informal inquiry and give full and truthful information</i> The Committee had sight of Mr Ausaluth's witness statement which detailed that the GDC had first attempted to make contact with Miss Brown on 25 July 2024. The Committee noted that Miss Brown had not responded and further communications via letter and email were sent. Miss Brown then responded via email on 30 September 2024. Following this date, the GDC sent further emails on 3 October 2024, 16 October 2024 and 25 October 2024, and attempted to call Miss Brown on 6 November 2024 but received no response. Further emails were sent on 15 November 2024, 22 November 2024 and 2 December 2024. The Committee noted that the only communication sent by Miss Brown after 3 October 2024 was on 22 November 2024 but this only amounted to an acknowledgement of the GDC's email and she did not provide the requested information. Taking all of this into consideration, the Committee determined that Miss Brown did not respond to the General Dental Council's enquiries from 3 October 2024 onwards and that this amounted to a failure to co-operate with its investigation. Accordingly, the Committee found this head of charge proved.
	2. Did not provide complete evidence regarding your indemnity cover. Found Proved The Committee noted from Mr Ausaluth's witness statement that the email sent by Miss Brown to the GDC contained '<i>partial indemnity as it covered the period of 2023-24 only</i>'. A response was sent to Miss Brown by the GDC via email on 16 October 2024 requesting indemnity certificates covering the period of 1 January 2015 until present. However, the Committee could see no evidence that this was provided by Miss Brown. Accordingly, the Committee found this head of charge proved.

Stage 2

21. 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 Miss Brown's fitness to practise is currently impaired by reason of 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 Miss Shehadeh, on behalf of the GDC, on the matters of misconduct, impairment and sanction.

Summary of the Committee's Findings of Fact

22. The Committee has found proved that, between August 2015 and February 2023, Miss Brown failed to provide an adequate standard of care to Patient A in respect of her radiographic practice and in identifying and treating gum disease. The Committee concluded that, owing to the diagnosis of advanced gum disease made by the STD in October 2023, this would have been ongoing for some time during Miss Brown's treatment of Patient A. No radiographs were taken by Miss Brown throughout her time treating Patient A and she failed to identify any signs of periodontal disease or subsequently treat it.

23. The Committee also found proved that Miss Brown failed to maintain adequate patient records for her appointments with Patient A. This included not recording regular Basic Periodontal Examination (BPE) scores, radiographic assessments, including justification and interpretation, detailed discussions of assessments, including diagnosis and treatment planning, and providing clinical data when recording a diagnosis. However, it did not find proved that Miss Brown failed to distinguish between gingivitis and periodontitis in the records.

24. Lastly, the Committee found proved that Miss Brown failed to co-operate with the GDC's investigation into her treatment of Patient A by not responding to the GDC's enquiries from 3 October 2024 onwards and not providing complete evidence of her indemnity.

Submissions

25. Miss Shehadeh, on behalf of the GDC, informed the Committee that Miss Brown has no fitness to practise history.

26. Miss Shehadeh invited the Committee to find that the facts found proved amount to misconduct. She referred to the relevant case law in respect of misconduct. She submitted that Miss Brown's conduct represented a serious departure from the GDC Standards. She also referred the Committee to Mr Malik's report and submitted that for all of the facts found proved in respect of the clinical matters, he had concluded that

Miss Brown's conduct had fallen far below the expected standard. She also invited the Committee to consider the seriousness of Miss Brown's non-compliance with the GDC's investigation.

27. In respect of impairment, Miss Shehadeh submitted that Miss Brown's fitness to practise is currently impaired on both public protection and public interest grounds. She referred the Committee to the relevant case law. She submitted that Miss Brown's treatment of Patient A spanned a lengthy period of time. She submitted that Miss Brown has provided no evidence of remediation, reflection or that she has undertaken further professional training or development. She submitted that although it is possible to remediate the concerns in this case, this has not been done as there has been no effort by Miss Brown to engage with these proceedings or to reflect on what went wrong with her treatment of Patient A. Miss Brown has also not shown any remorse. Therefore, she submitted that it is likely that Miss Brown would repeat these failings in future.
28. Miss Shahadeh submitted that failing to provide good clinical care and failing to comply with a GDC investigation strikes at the core principles of the dental profession. She submitted that if a finding of impairment was not made, a fully informed member of the public would be shocked and confidence in the dental professions would be undermined.
29. With regard to sanction, Miss Shehadeh invited the Committee to impose a suspension order on Miss Brown's registration for a period between six to nine months with a review hearing.

Committee's Decision

30. 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 document titled, '*Fitness to Practise: Guidance for the practice committees*' (effective from 6 January 2026) (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

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

- 1.4 *You must take a holistic and preventative approach to patient care which is appropriate to the individual patient.*

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes.

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.

Radiographs, consent forms, photographs, models, audio or visual recordings of consultations, laboratory prescriptions, statements of conformity and referral letters all form part of patients records where they are available.

4.1.2 You should record as much detail as possible about the discussions you have with patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.

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

7.1.1 You must find out about current evidence and best practice which affects your work... and follow them.

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

9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association.

32. The Committee first considered the clinical failings in this case. It has found proved that there were serious and wide-ranging failings in respect of basic and fundamental areas of dentistry in respect of Miss Brown's treatment of Patient A. These failings included the areas of radiographic practice, the assessment and treatment of periodontal disease, record keeping and not properly investigating the reasons for repeated failure of the restoration on Patient A's UL1. These failings were repeated over roughly an eight year period and therefore cannot be said to be isolated, but rather formed a pattern of behaviour that ultimately caused Patient A harm.

33. The Committee also took into account Mr Malik's report. It noted from that report the guidelines that Miss Brown should have adhered to but had failed to do so during her care of Patient A. These guidelines included the following: *FGDP (UK) Standards in Dentistry (2016)*; *BSP guidance on Basic Periodontal Examination and periodontal*

management; NICE Clinical Guideline CG19 (Dental Recall) regarding risk-based recall and radiographic interval assessment and IR(ME)R regulations governing radiographic justification and reporting. The Committee also noted the conclusions of Mr Malik's report, which stated that for all the clinical matters found proved, Miss Brown's conduct fell far below the expected standard.

34. In conclusion, the Committee determined that Miss Brown's clinical failings were clearly serious and represented a significant departure from the relevant GDC Standards and guidelines. The Committee determined that this amounted to a finding of misconduct.
35. In respect of Miss Brown's failure to co-operate with the GDC's investigation, the Committee also considered that this was serious. Being a registered dental professional, Miss Brown would have been aware of the importance of fully complying with any investigation by the GDC as outlined in the GDC Standards. However, despite repeated requests from the GDC, Miss Brown failed to respond to the GDC's enquiries from October 2024 onwards or provide the GDC with complete information about her indemnity cover.
36. The Committee determined that this amounted to a serious departure from the GDC Standards and clearly met the threshold for a finding of misconduct.

Impairment

37. The Committee then considered whether Miss Brown's fitness to practise is currently impaired by reason of her misconduct.
38. The Committee first considered that both the clinical and conduct failings in this case were capable of being remedied. The Committee took into account that the clinical failings related to fundamental and basic areas of dentistry and could be remedied by further training and development. In respect of the conduct concerns, these could be remedied by Miss Brown's full co-operation and engagement with these proceedings and complying with any requests from the GDC.
39. However, the Committee has seen no evidence of insight and remediation from Miss Brown, including whether she has reflected on her clinical failings, the impact on Patient A, and how she would make sure this conduct is not repeated. In respect of her non-co-operation with the GDC, the Committee noted that this has continued until this hearing and Miss Brown has still not provided complete evidence of her indemnity insurance, and this therefore potentially puts patients at risk. There has also been no evidence of remorse from Miss Brown for her actions or an apology to Patient A for causing her harm. Furthermore, there is no evidence before the Committee that she has undertaken any targeted Continuing Professional Development (CPD) courses to address the clinical issues. The Committee concluded therefore that without any

evidence of insight and remediation, there was a significant risk that Miss Brown could repeat the misconduct it has found and this would put patients at risk of harm.

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

41. 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. Miss Brown's actions fell far below the required standard in basic and fundamental areas of dentistry and resulted in harm to Patient A. Miss Brown's conduct also showed a disregard for and undermined the GDC's important role in regulating the dental profession. 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.

42. The Committee therefore determined that Miss Brown's fitness to practise is also currently impaired on the ground of public interest.

Sanction

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

44. The Committee considered the mitigating and aggravating factors in this case as outlined in the GDC's Guidance.

45. The only mitigating factor in this case is that Miss Brown is of previous good character.

46. The aggravating factors in this case include the following:

- Actual harm to a patient;
- Misconduct sustained or repeated over a period of time – the Committee noted that Miss Brown's treatment of Patient A was over an eight-year period, 2015 to 2023;
- Blatant or wilful disregard of the role of the GDC and the systems regulating the professions; and
- No evidence of insight.

47. 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 and the Committee's finding of current impairment.
48. The Committee then considered the available sanctions in ascending order starting with the least serious.
49. 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.
50. The Committee considered whether a conditions of practice order would be appropriate. It noted that the clinical failings in this case could be addressed by the imposition of conditions. However, Miss Brown has not engaged with these proceedings or complied with the GDC's investigation since October 2024. Therefore, the Committee could not be confident that she would comply with any set of conditions. Furthermore, the Committee considered that conditions would not adequately address Miss Brown's failure to co-operate with the GDC's investigation and concluded that imposing conditions on her practice would not be sufficient or proportionate to maintain public confidence in the profession.
51. The Committee then considered whether an order of suspension would be appropriate to mark the nature and severity of the misconduct. It noted in the *GDC's Guidance* that suspension is appropriate for more serious cases when:
- There is evidence of repetition of the behaviour.
 - The registrant has not shown insight into the issues which led to a finding of current impairment being made, and/or poses a significant risk of repeating the behaviour.
 - A lesser sanction would be insufficient to meet the public interest.
52. The Committee considered that all of the above factors were relevant in this case. The Committee recognised that both the clinical and conduct failings were serious and represented a serious departure from the GDC's Standards. The clinical failings were basic and fundamental, occurred over a lengthy period of time and caused harm to Patient A. Miss Brown then did not engage with the GDC's investigation or provide complete evidence of indemnity as requested. The Committee considered that as there has been no evidence of insight or remediation into these failings there was real risk of repetition which would put patients at risk of harm. The Committee determined,

therefore, that a suspension order was appropriate and proportionate. This would protect the public and suitably mark the seriousness of the Miss Brown's misconduct by addressing the public interest concerns.

53. The Committee gave consideration to the option of erasure but determined that such a step would be disproportionate. While recognising that the failings in this case are serious, in particular Miss Brown's non-co-operation with the GDC's investigation, the Committee did not consider it to be so serious that her conduct is fundamentally incompatible with continued registration. In coming to that view, the Committee has borne in mind that the misconduct is capable of being remedied and that it should only impose the least restrictive sanction that would adequately protect the public and public interest concerns. The Committee concluded that a suspension order would suitably address both matters.

54. Accordingly, having had regard to all of the evidence, the Committee has determined to direct that Miss Brown's registration be suspended for a period of 12 months. The Committee is satisfied that this period of time is sufficient to mark the nature and extent of Miss Brown's failings in this case, to uphold professional standards and to maintain public confidence in the profession and the regulatory system. This period of time would also give Miss Brown the opportunity to engage with the GDC and remediate the concerns.

55. The Committee also directs that the suspension order be reviewed before its expiry. It considered that a future reviewing Committee may be assisted by the following evidence:

- Evidence of any CPD courses undertaken targeted to the concerns in this case;
- Evidence of remorse shown and insight into the clinical concerns, including written reflections on how Miss Brown's conduct had an impact on Patient A and the public's confidence in the profession; and
- Written reflections on the importance of co-operating with the GDC.

56. The Committee now invites submissions as to whether Miss Brown's registration should be suspended immediately.

Decision on Immediate Order – 9 September 2026

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

58. Miss Shehadeh, on behalf of the GDC, invited the Committee to impose an immediate order of suspension on Miss Brown's registration. She submitted that an immediate

order is necessary for public protection given the clinical findings identified by the Committee.

59. The Committee has considered the submission made. It has accepted the advice of the Legal Adviser.
60. The Committee was satisfied that, given the nature of its findings and its reasons for the substantive order of suspension in Miss Brown's case, it is necessary to direct that an immediate order be imposed on the grounds of public protection and the public interest. The Committee considered that, given its findings, if an immediate order was not made in the circumstances, there would be a real risk of harm to the public and public confidence in the profession would be undermined.
61. The effect of the foregoing determination and this order is that Miss Brown's registration will be suspended immediately from the date on which notice is deemed to have been served upon her. Unless she exercises her right of appeal, the substantive direction for suspension 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 Miss Brown exercises her right of appeal, this immediate order will remain in place until resolution of the appeal.
62. The Committee also directs that the interim order currently in place on Miss Brown's registration should be revoked.
63. That concludes this hearing.
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