GENERAL DENTAL COUNCIL

AND

TAHIR, Shahzad

[Registration number: 176728]

NOTICE OF INQUIRY

SUBSTANTIVE HEARING

Notice that an inquiry will be conducted by a Practice Committee of the General Dental Council commencing at **10:00am** on **28 April 2025.**

The General Dental Council
37 Wimpole Street
London
W1G 8DQ

The heads of charge contained within this sheet are current at the date of publication. They are subject to amendments at any time before or during the hearing. For the final charge, findings of fact and determination against the registrant, please visit the Recent Decisions page at https://www.dentalhearings.org/hearings-and-decisions/decisions after this hearing has finished.

Committee members:	Carson Black	Dentist Chair
	Jim Hurden	Lay
	Caroline Ross	DCP
Legal Adviser:	Karen Rea	

CHARGE

TAHIR, Shahzad, a dentist, BDS University of Wales 2009 is summoned to appear before the Professional Conduct Committee on 28 April 2025 for an inquiry into the following charge:

The Charge

The hearing will be held to consider the following charge against you:

"Shahzad Tahir, *that being a registered dentist:-*

Patient 1

1. On or around 9 April 2019 you recorded that Patient 1 was informed that "she attended in Jan 18 for a pain appt and UL7 caries was not treated (just coated with fluoride) and the sinus related to UR6 was not treated."
2. The concern raised with Patient 1 and recorded at allegation 1 was not valid and/or that you failed to record the context in which the care was provided in January 2018 in particular that it was an emergency appointment.
3. That your conduct at allegation 2 was misleading.

Patient 2

4. On or around 2 July 2019 you recorded that "PA taken LR6 – widened PDL at apex of mesial root and v deep am filling present. Advised options are to nothing/ rct/ xtn. Pt wants xtn. Pt not happy that this tooth was not treated properly in the past by {Dentist A} and this has led to deep decay under the fillings he has placed…"
5. You failed to provide Patient 2 with a balanced record of their care in particular failed to record that you had not identified and restored the caries at LR6 in a timely fashion.
6. That your conduct at 5 was misleading.

Patient 3

7. On or around 7 March 2019 you recorded that you "advised pt caries was not fully removed before am filling was placed and so the caries has increased in size and may have not gone into pulp – advised options are to nothing/attempt to restore took but if caries has gone into pulp he will need ract/ext patient accepts and wants to try and save tooth"
8. It was incorrect to advise Patient 3 that the caries at LL6 were not fully removed.

9. You failed to provide Patient 3 with a balanced record of their care in that you failed to record that there were other issues with the care that had been afforded to them, in particular:

   (i) A bitewing radiograph exposed by Dentist B in 2014 evidenced caries at LL6 which were not diagnosed and/or treated by Dentist B.

   (ii) No bitewing radiographs had been exposed by the Registrant in July 2017 despite it being 2 years since the previous bitewings had been exposed.

   (iii) You failed to diagnose the caries at LL6 when reviewing the previous bitewings exposed in 2014.

10. Your conduct at allegation 8 and/or allegation 9 (i) and or allegation 9(ii) and/or allegation 9 (iii) was misleading.

11. On or around 28 July 2017 you informed and/or recorded that you informed Patient 3 "that as NHS resources are limited we are unable to complete tmt on NHS".

12. Your conduct at allegation 11 was:

   (i) Misleading; and/or

   (ii) Dishonest.

Patient 4

13. On or around 23 April 2019 you advised Patient 4's husband that "Feb 17: BWs were taken but caries was diagnosed in LL8, LR7 and UR8. Band 2 treatment was claimed for 1 filing"

14. It was incorrect to advise Patient 4's husband that caries had been diagnosed at LL8 and LR7.

15. Your conduct at allegation 14 was misleading.

Patient 5

16. On or around 12 March 2019 you recorded that you "advised pt that BWs xrays should have been taken when {Dentist A} first started seeing her as they should be taken at least every 2 years according to guidelines and the last time she had them done was in 2013. Had these been done it is possible that issues with UL5, UR4, LL6, LR5 and LR7 may have been spotted earlier".

17. You failed to record that other causative issues, other than a delay in exposing radiographs, could have been a factor in the issues identified at UR4, LL6 and/or LR7.

18. Your conduct at allegation 17 was misleading.

Patient 6

19. On or around 12 March 2019 you recorded that you "advised pt BWs taken on 24/10/17 show deep decay in UR7 – this should have been spotted earlier by {Dentist A} had he taken BWs earlier. Advised pt BWs should be taken at least once every 2 years and more often than that if caries risk is not low."

20. In advising Patient 6 as set out at allegation 19 you failed to record a delay of 8 months in exposing radiographs would not result in significant progression of the carious lesion.

21. Your conduct at allegation 20 was misleading.

Patient 7

22. On 12 March 2019 you recorded in Patient 14's record "advised pt we need to check UR7 as {Dentist A}'s notes state that he did not find any caries in the tooth..,{Dentist A}'s notes state no caries was visible when he removed the GIC filling I placed. I advised pt this is highly unlikely as the photo shows clear decay."

23. On 19 March 2019 you failed to provide Patient 7 with a balanced record of their care in that you did not record that Dentist A may have been clinically correct when advised that there was no caries at UR7.

24. Your conduct at allegation 23 was misleading.

Patient 8

25. On 12 March 2019 you recorded "advised pt the BW xrays taken in 2017 show – deep decay at LL4. This would have been spotted sooner if {Dentist A} had taken xrays but was left untreated – caries UL7 distal which was left untreated – sub calculus which made perio condition worse. This calculus should have been identified and removed earlier had MI taken xrays when he should have done".

26. It was incorrect to record that Dentist A had left caries untreated at UL7.

27. You failed to record that you advised Patient 8 of other issues with the care that had been afforded to them in particular:

    (i) That between 23 June 2014 and 14 January 2016 Dentist C did not expose any bitewing radiographs.

    (ii) That the matters alleged at (i) above, would have had the same causative harm as that recorded for Dentist A.

28. Your conduct at allegation 26 and/or allegation 27(i) and/or allegation 27(ii) was misleading.

Patient 9

29. On 19 March 2019, you recorded “advised pt that photos taken on 7/8/17 (uploaded to file on 8/3/19) show gross caries UL1 and UR1 which should have been addressed prior to her appt with me on 7/8/17 and had this been done they might have been saved. However, the notes by {Dentist A} before 7/8/17 do not make any mention of the gross decay in these teeth so it was diagnosed or treated and the text of the caries visible in photos shows that the decay must have been there for some time – it cannot have just developed in between her last appt with {Dentist A} on 8/2/17 and next appt with me on 7/8/17.”

30. It was incorrect to record that the loss of the UR1 was due to the Dentist A’s failure to diagnose caries.

31. You failed to advise and/or record the condition of the UR1, prior to attending with Dentist A and its causative impact.

32. You failed advise and/or record alternate possibilities as to the pathology of UR1 and/or the involvement of other dentists in that regard.

33. Your conduct at allegation 30 and/or allegation 31 and/or allegation 32 was misleading.

Patient 10

34. On 12 March 2019 you recorded an entry as found in Schedule 1.

35. You failed to advise and/or record that Dentist D, Dentist C, Dentist E, and Dentist F had not exposed bitewing radiographs on Patient 10.

36. You failed to record why the UR3 was extracted and /or advise that it was due to trauma.

37. Your conduct at allegation 35 and/or allegation 36 was misleading.

Patient A

38. On or around 11 March 2019, you arranged for Patient A to be contacted by Witness 5 to say that Dentist A had not treated patients well and that she may be entitled to compensation.

39. On or around 14 May 2020, you arranged for Patient A to be contacted by a member of your practice to provide details of the solicitor firm to contact in order to obtain compensation for a dental claim,

40. Your conduct in respect to 38 and/or 39 above was:-

    a. Lacking in integrity;

    b. Misleading

    c. Dishonest in that you knowingly witheld information from Patient A about the practice complaints procedure with the intention of

encouraging Patient A to contact a specific solicitor's firm to seek compensation.

NHS and GDC investigation

41. From 18 April 2019 to January 2021 you continued to provide inaccurate and/or misleading descriptions of the care provided to Patient 2 and/or Patient 4 subsequent to the NHSE meeting on 18 April 2019, in which you were advised to be cautious about discussing previous treatment conducted by Dentist A with his former patients.

42. Your conduct in respect to 41 was lacking in integrity.

43. Between September 2018 and March 2019, you filed and/or arranged to be filed a pop-up note on patients' computerised records saying "give [REDACTED] card" and/ or "[REDACTED] solicitors card given" and/ or "taking legal action against [REDACTED]" and/or words to that effect.

44. Your conduct in respect to 43 was lacking in integrity.

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