Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING
Professional Conduct Committee
Initial Hearing

27 July – 7 August 2026

Name:	GAMBA, William
Registration number:	67082
Case number:	CAS-205053 CAS-207878

General Dental Council:	Tom Stevens, Counsel Instructed by
Registrant:	Not present Unrepresented

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

Committee members:	Chris Weigh	(Chair and Lay Member)
	Sukhninder Sandhar	(Dentist Member)
	Victoria Hewson	(Dental Care Professional Member)
Legal adviser:	Alastair McFarlane	
Committee Secretary:	Kate Anderson	

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1. This was a Professional Conduct Committee (PCC) inquiry into the facts which formed the basis of the allegation against Mr Gamba that his fitness to practise is impaired by reason of misconduct.

2. Mr Gamba, was neither present nor represented at the hearing. Mr Tom Stevens, Counsel, appeared on behalf of the General Dental Council (GDC).

3. The hearing was held remotely on Microsoft Teams.

The Charges

4. The charges in this case are as follows:

"That being a registered dentist,

A. You practised as a dentist at the dental practice referred to in Schedule 10F[1] below ("the Practice") and treated the patients listed below (and referred to in Schedule 1).

Treatment and Record Keeping Failures

B. You failed to provide an adequate standard of care, with regard to treatment and record keeping, from 30 October 2020 to 22 May 2024, for Patients 1 to 15, in that:

Patient 1

1. *During an appointment on 28 February 2022:*
    a. *you did not take a post operative radiograph, covering Patient 1's LR6, after completing root canal treatment.*
2. *You did not record:*
    a. *any details of your examination findings on 1 February 2022*
    b. *sufficient details of the treatment you provided on*
        i. *28 February 2022;*
        ii. *31 August 2023;*
    c. *Details of the local anaesthetic you used during root canal treatment on 28 February 2022.*
3. *You did not report on radiographs taken on:*
    a. *1 February 2022;*
    b. *28 February 2022.*

Patient 2

4. *You did not take a medical history and/or medical history update for Patient 2 on 25 January 2022.*
5. *You did not record:*

[1] Please note the Schedules are private documents that cannot be disclosed.

a. *any details of your examination findings and/or sufficient details of the treatment you provided on 25 January 2022;*

b. *any details of your examination findings on 8 August 2023;*

6. *You did not report on radiographs taken on 25 January 2022.*

Patient 3

7. *You did not take any bitewing radiographs during an appointment on 29 July 2021.*

8. *You did not record any details of your examination findings on:*

   a. *29 July 2021.*

Patient 4

9. *You did not take a medical history and/or medical history update for Patient 4 on:*

   a. *28 February 2022;*

   b. *26 January 2023.*

   c. *You did not take any bitewing radiographs during an appointment on 28 February 2022 or 26 January 2023.*

10. *You did not record any details of your examination findings on:*

    a. *28 February 2022;*

    b. *26 January 2023.*

Patient 5

11. *You did not take a medical history and/or medical history update for Patient 5 on:*

    a. *11 January 2023;*

    b. *5 July 2023.*

12. *You did not record any details of your examination findings on:*

    a. *11 January 2023;*

    b. *5 July 2023.*

Patient 6

13. *You did not take a medical history and/or medical history update for Patient 6 on:*

    a. *16 May 2023;*

    b. *12 June 2023.*

14. *You did not record:*

    a. *any details of your examination findings on 12 June 2023;*

    b. *details of the local anaesthetic you used during an appointment on:*

       i. *16 May 2023;*

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ii. 12 June 2023;

iii. 3 July 2023.

15. You did not report on radiographs taken on:

a. 16 May 2023;

b. 12 June 2023.

Patient 7

16. You did not take any bitewing radiographs during an appointment on 27 September 2022.

17. You did not record:

a. any details of your examination findings on 27 September 2022;

b. details of the local anaesthetic you used during an appointment on 27 September 2022.

18. You did not report on a radiograph taken on 27 October 2022

Patient 8

19. You did not record:

a. any details of your examination findings and/or any details of Patient 8's presenting complaint on 30 January 2023;

b. sufficient details of the treatment you provided on:

i. 17 February 2023;

ii. 24 March 2023;

c. details of the local anaesthetic you used during an appointment on:

i. 17 February 2023;

ii. 24 March 2023;

d. any details of when Patient 8's LL5 was prepared for the crown that was fitted on 24 March 2023.

20. You did not report on radiographs taken on:

a. 30 January 2023;

b. 17 February 2023;

c. 22 June 2023.

Patient 9

21. You did not take a medical history and/or medical history update for Patient 9 on:

a. 30 January 2023.

22. You did not record sufficient details of your examination findings on:

a. 30 January 2023.

Patient 10

23. *During an appointment on 24 October 2022, you did not take:*
    a. *any bitewing radiographs;*
    b. *a medical history and/or medical history update for Patient 10.*

24. *You did not record sufficient details of your examination findings on 24 October 2022.*

Patient 11

25. *You did not take a medical history and/or medical history update for Patient 11 on:*
    a. *19 January 2021;*
    b. *10 May 2023;*
26. *You did not take any bitewing radiographs during an appointment on 10 May 2023.*
27. *You did not record any details of your examination findings on*
    a. *19 January 2021.*

Patient 12

28. *During an appointment on 31 May 2023, you:*
    a. *did not take any bitewing radiographs;*
    b. *took a radiograph covering Patient 12's upper molar teeth, without appropriate clinical justification.*
    c. *Did not report on a radiograph taken.*
29. *You did not record any details of your examination findings on 31 May 2023.*

Patient 13

30. *You did not take any bitewing radiographs during an appointment on:*
    a. *21 December 2022.*
31. *You did not record any details of your examination findings on:*
    a. *21 December 2022.*

Patient 14

32. *For an appointment on 31 May 2023, you did not record:*
    a. *Patient 14's presenting complaint;*
    b. *any details of your examination findings;*
    c. *a diagnosis.*

Patient 15

33. *You did not take any bitewing radiographs during an appointment on 12 January 2023.*
34. *You did not record:*

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a. *any details of your examination findings on 12 January 2023;*

b. *Details of the local anaesthetic you used during an appointment on 12 January 2023.*

Practising whilst Suspended

C. Between 16 and 24 May 2024, you provided dental services whilst your General Dental Council registration was subject to an interim suspension order.

D. Your conduct in Charge C. put patient safety at risk.

Failing to cooperate with the GDC

E. From 21 November 2024 to 29 January 2025, you failed to cooperate with an investigation conducted by the General Dental Council in that you did not respond to the GDC's requests for information.

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct (in relation to charges B1-35, C, D and E) and/or deficient professional performance (in relation to charges B1-35)".

Preliminary matters

5. The Committee first considered the issues of service and whether to proceed with the hearing in the absence of Mr Gamba. The Committee heard submissions from Mr Stevens. 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

6. The Committee considered whether notice of the hearing had been served on Mr Gamba in accordance with Rules 13 and 65 of the GDC (Fitness to Practise) Rules Order of Council 2006 ('(hereby referred to as 'The Rules') and Section 50A of the Dentists Act 1984 (as amended) ('the Act'). The Committee heard submissions from Mr Stevens and accepted the advice of the Legal Adviser.

7. The Committee received from the GDC an indexed hearing bundle, which contained a copy of the Notice of Hearing (NOH), dated 15 June 2026. The hearing bundle also contained a Royal Mail 'Track and Trace' receipt confirming that the notice was sent to Mr Gamba's registered address by Special Delivery. The Committee took into account that there is no requirement within the Rules for the GDC to prove delivery of the NOH, only that it was sent. However, it noted proof of delivery where it was signed for by 'GAMBA' on 16 June 2026. A copy of the NOH was also sent by first class post and emailed to Mr Gamba on 15 June 2026.

8. The Committee was satisfied that the notice sent to Mr Gamba contained proper notification of today's hearing, including its time, date and that it will be conducted

remotely, as well as notification that the Committee had the power to proceed with the hearing in Mr Gamba's absence.

9. On the basis of the information provided, the Committee was satisfied that notice of the hearing had been served on Mr Gamba in accordance with the Rules and the Act.

Decision on Proceeding in the Registrant's Absence

10. The Committee next considered whether to exercise its discretion under Rule 54 of the Rules to proceed with the hearing in the absence of Mr Gamba. It approached this issue with the utmost care and caution. The Committee took into account the factors to be considered in reaching its decision, as set out in the case of *R v Jones [2002] UKHL 5* and *GMC v Adeogba & Visvardis* [2016] *EWCA Civ 162.* It remained mindful of the need to be fair to both Mr Gamba and the GDC, taking into account the public interest in the expeditious consideration of any interim order.

11. The Committee was satisfied that all reasonable efforts had been made by the GDC to notify Mr Gamba of the hearing, and that the NOH had been served on his registered address in accordance with the Rules and the Act. It noted that Mr Gamba has not corresponded with the GDC since December 2024, despite repeated attempts by the GDC to engage with him. There has been no response from Mr Gamba in relation to the NOH. The Committee was therefore satisfied that the GDC had made all reasonable attempts to inform Mr Gamba of the hearing and he was aware of the hearing given that there was evidence he had signed for the NOH. The Committee therefore was satisfied that Mr Gamba had voluntarily absented himself from today's hearing.

12. It was the conclusion of the Committee that adjourning the hearing would serve no meaningful purpose in the circumstances. It noted that Mr Gamba had not requested an adjournment and there was no information before it to suggest that deferring the hearing would secure Mr Gamba's attendance in future.

13. The Committee remained mindful of the overarching statutory objective of the GDC, which is the protection of the public and the wider public interest, and its duty to act expeditiously in the public interest. The Committee also took into account the need to be fair to the GDC, noting that it is prepared and ready to present its case, and has witnesses prepared to give evidence.

14. The Committee was satisfied, having balanced the public interest and fairness to the regulator with fairness to Mr Gamba, that the balance weighed in favour of proceeding with the hearing in Mr Gamba's absence.

Rule 25 joinder application

15. Mr Stevens next made an application for joinder under Rule 25(2) of the Rules. The application was to join new allegations to the existing charges following receipt of the expert's opinion report.

16. Rule 25(2) states that:

> *Where—*
>
> *(a) an allegation against a respondent has been referred to a Practice Committee,*
>
> *(b) that allegation has not yet been heard, and*
>
> *(c) a new allegation against the respondent which is of a similar kind or is founded on the same alleged facts is received by the Council,*
>
> *the Practice Committee may consider the new allegation at the same time as the original allegation, notwithstanding that the new allegation has not been included in the notification of hearing.*

17. Mr Stevens submitted that the additional allegations had arisen from Mr Kramer's expert report, which was not available when the Case Examiners first referred the allegations to the Professional Conduct Committee. He submitted that some of the further criticisms fit within the same parameters as previously referred, but that there were also additional criticisms relating to Mr Gamba's clinical practise as identified in the 15 patient records.

18. Mr Stevens submitted that the allegations had not yet been heard, that the additional allegations are of a similar kind, and are founded on the same alleged facts to those listed within the NOH. Mr Stevens also submitted that sub-section 3 of rule 25 deals with the matter of informing the registrant of an application for joinder and the additional allegations and the timeframe for doing so. Mr Stevens submitted that Mr Gamba was formally notified on 15 June 2026 of the GDC's intention to apply for a joinder under rule 25, and he therefore was provided with sufficient time to provide any written representations in relation to the matter within the 28 day period stipulated in the Rules.

Committee's decision on rule 25 application

19. The Committee heard and accepted the legal advice in relation to the joinder application.

The Committee was satisfied that the pre-conditions for a rule 25 applications were met. It noted that Mr Gamba had been informed of the GDC's intention to apply for a rule 25 application in December 2025, and he had received formal notice on 8 June 2026. The Committee was also satisfied that Mr Gamba had been informed within the timeframe

stipulated in the Rules and that he had a fair opportunity to provide any representations. The Committee was satisfied that Mr Gamba had chosen to disengage.

20. The Committee was satisfied that it was appropriate to consider the new allegations at the same time. The Committee accepted that the additional allegations were of a similar kind, and were founded on the same facts. The further allegations came from Mr Kramer's analysis of the clinical records of 15 patients treated by Mr Gamba. The Committee determined that in the public interest, and in the interest of fairness, the addition of the further charges would ensure that the matters were dealt with expeditiously.

21. Accordingly, the Committee granted the joinder application.

Rule 18 Amendment to the charge application

22. Mr Stevens made an application under rule 18 of the Rules to amend the charges at this hearing.

23. He submitted that the charges should be amended insofar as their numbering, so that the numbering would be in line with the charges as set out in the letter sent to Mr Gamba in December 2025. He submitted that this was a clerical change that would cause no prejudice.

24. Mr Stevens also applied to amend the allegations at B, from being alleged as both misconduct and deficient professional performance, to those being alternatives. This would be effected by substituting '*or*' for '*and/or*'. He submitted that the GDC's primary position was that the alleged clinical conduct constituted misconduct and that deficient professional performance was better alleged as an alternative, which the Committee would consider if it was not satisfied as to the misconduct basis of impairment. Mr Stevens submitted that the matters at C and/or D and/or E, if found proved, would also amount to misconduct.

Committee's decision on amending the charge

25. The Committee heard and accepted legal advice in relation to amending the charge at this hearing.

26. The Committee was satisfied that the charge could be amended without causing injustice. The amendments to the numbering, were to correct typographical errors and reflected the charges Mr Gamba had received in December 2025. The amendment to make misconduct an alternative to deficient professional performance, narrowed the scope of the allegations. The Committee therefore acceded to the application.

The Amended Charge

27. The Charge, as amended at this hearing, is as follows:

'That being a registered dentist,

A. *You practised as a dentist at the dental practice referred to in Schedule 1 below ("the Practice") and treated the patients listed below (and referred to in Schedule 1 below).*

Treatment and Record Keeping Failures

B. *You failed to provide an adequate standard of care, with regard to treatment and record keeping, from 30 October 2020 to 22 May 2024, for Patients 1 to 15, in that:*

Patient 1

1. *During an appointment on 28 February 2022:*
    a. *you carried out RCT on Patient 1's LR6 without using a rubber dam;*
    b. *you did not take a post operative radiograph, covering Patient 1's LR6, after completing root canal treatment.*

2. *You did not record:*
    a. *any details of your examination findings on 1 February 2022;*
    b. *sufficient details of the treatment you provided on*
        i. *28 February 2022;*
        ii. *31 August 2023;*
    c. *Details of the local anaesthetic you used during root canal treatment on 28 February 2022.*

3. *You did not report on radiographs taken on:*
    a. *1 February 2022;*
    b. *28 February 2022.*

Patient 2

4. *You did not take a medical history and/or medical history update for Patient 2 on 25 January 2022.*

5. *You did not record:*
    a. *any details of your examination findings and/or sufficient details of the treatment you provided on 25 January 2022;*
    b. *any details of your examination findings on 8 August 2023;*

6. *You did not report on radiographs taken on 25 January 2022.*

Patient 3

7. *You did not take any bitewing radiographs during an appointment on 30 October 2020 or 29 July 2021.*

8. *You did not record any details of your examination findings on:*
    a. *30 October 2020;*
    b. *29 July 2021.*

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Patient 4

9. *You did not take a medical history and/or medical history update for Patient 4 on:*
    a. *31 March 2021;*
    b. *28 February 2022;*
    c. *26 January 2023.*

10. *You did not take any bitewing radiographs during an appointment on 31 March 2021 or 28 February 2022 or 26 January 2023.*

11. *You did not record any details of your examination findings on:*
    a. *31 March 2021;*
    b. *28 February 2022;*
    c. *26 January 2023.*

Patient 5

12. *You did not take a medical history and/or medical history update for Patient 5 on:*
    a. *20 November 2020;*
    b. *19 May 2021;*
    c. *18 October 2021;*
    d. *12 May 2022;*
    e. *11 January 2023;*
    f. *5 July 2023.*

13. *You did not take any bitewing radiographs during an appointment on 20 November 2020 or 19 May 2021.*

14. *You did not record any details of your examination findings on:*
    a. *19 May 2021;*
    b. *3 February 2022;*
    c. *11 January 2023;*
    d. *5 July 2023.*

Patient 6

15. *You did not take a medical history and/or medical history update for Patient 6 on:*
    a. *16 May 2023;*
    b. *12 June 2023.*

16. *During an appointment on 3 July 2023, you inappropriately provided a filling including the distal aspect of Patient 6's LR5.*

17. *You did not record:*
    a. *any details of your examination findings on 12 June 2023;*
    b. *details of the local anaesthetic you used during an appointment on:*
        i. *16 May 2023;*
        ii. *12 June 2023;*
        iii. *3 July 2023.*

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18. *You did not report on radiographs taken on:*
    a. *16 May 2023;*
    b. *12 June 2023.*

Patient 7

19. *You did not take any bitewing radiographs during an appointment on 2 September 2022.*

20. *You did not record:*
    a. *any details of your examination findings on 27 September 2022;*
    b. *details of the local anaesthetic you used during an appointment on 27 September 2022.*

21. *You did not report on a radiograph taken on 27 October 2022*

Patient 8

22. *During an appointment on 30 January 2023, you prescribed antibiotics without an appropriate clinical justification.*

23. *During an appointment on 17 February 2023 you carried out RCT on Patient 8's LL5 without using a rubber dam;*

24. *You did not record:*
    a. *any details of your examination findings and/or any details of Patient 8's presenting complaint on 30 January 2023;*
    b. *sufficient details of the treatment you provided on:*
        i. *17 February 2023;*
        ii. *24 March 2023;*
    c. *details of the local anaesthetic you used during an appointment on:*
        i. *17 February 2023;*
        ii. *24 March 2023;*
    d. *any details of when Patient 8's LL5 was prepared for the crown that was fitted on 24 March 2023.*

25. *You did not report on radiographs taken on:*
    a. *30 January 2023;*
    b. *17 February 2023;*
    c. *22 June 2023.*

Patient 9

26. *You did not take a medical history and/or medical history update for Patient 9 on:*
    a. *28 April 2021;*
    b. *30 January 2023.*

27. *You did not record sufficient details of your examination findings on:*
    a. *28 April 2021;*

b. 30 January 2023.

Patient 10

28. During an appointment on 24 October 2022, you did not take:
    a. any bitewing radiographs;
    b. a medical history and/or medical history update for Patient 10.

29. You did not record sufficient details of your examination findings on 24 October 2022.

Patient 11

30. You did not take a medical history and/or medical history update for Patient 11 on:
    a. 19 January 2021;
    b. 10 May 2023;

31. You did not take any bitewing radiographs during an appointment on 10 May 2023 or 22 May 2024.

32. You did not record any details of your examination findings on
    a. 19 January 2021.

Patient 12

33. During an appointment on 31 May 2023, you:
    a. did not take any bitewing radiographs;
    b. took a radiograph covering Patient 12's upper molar teeth, without appropriate clinical justification.
    c. Did not report on a radiograph taken.

34. You did not record any details of your examination findings on 31 May 2023.

Patient 13

35. You did not take any bitewing radiographs during an appointment on:
    a. 5 November 2020;
    b. 5 May 2022;
    c. 21 December 2022.

36. You did not record any details of your examination findings on:
    a. 5 November 2020;
    b. 5 May 2022;
    c. 21 December 2022.

Patient 14

37. During an appointment on 31 May 2023, you prescribed antibiotics without an appropriate clinical justification.

38. For an appointment on 31 May 2023, you did not record:
    a. Patient 14's presenting complaint;
    b. any details of your examination findings;

c. a diagnosis.

39. You did not report on a radiograph taken on 31 May 2023;

Patient 15

40. You did not take any bitewing radiographs during an appointment on 12 January 2023.

41. You did not record:
a. any details of your examination findings on 12 January 2023;
b. Details of the local anaesthetic you used during an appointment on 12 January 2023.

Practising whilst Suspended

***C.** Between 16 and 24 May 2024, you provided dental services whilst your General Dental Council registration was subject to an interim suspension order.*

***D.** Your conduct in Charge C. put patient safety at risk.*

Failing to cooperate with the GDC

***E.** From 21 November 2024 to 29 January 2025, you failed to cooperate with an investigation conducted by the General Dental Council in that you did not respond to the GDC's requests for information.*

AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct (in relation to charges B1-41, C, D and E) or deficient professional performance (in relation to charges B1-41).'

Background to the case and summary of allegations

28. In opening the case for the GDC, Mr Stevens provided the Committee with oral submissions of the background of this case and a summary of the allegations.

29. Mr Stevens informed the Committee that the GDC became aware of alleged clinical failings in Mr Gamba's practice in 2023, mainly related to his record keeping, and that an independent investigation into his clinical practice was carried out. The GDC obtained a list of patients who were treated by Mr Gamba between October 2022 and October 2023. It randomly selected 15 patients and sought their complete records to review.

30. Mr Stevens informed the Committee that the GDC obtained all of the available records for these patients, including any radiographs. Mr Kramer, the Dental Expert witness, was then instructed to make an expert report based on these records. Mr Stevens told the Committee that Mr Kramer identified failings that were thematically similar in relation to many of the patients.

31. Mr Stevens took the Committee through the specific charges and failings, and their evidential basis. He summarised the charges in that B related to the Mr Gamba's clinical failings in relation to the 15 patients, C that Mr Gamba proceeded to treat patients whilst under an interim order of suspension, and D that Mr Gamba failed to provide the GDC with information when requested which is a standard required of a registered dental professional.

Evidence

32. Mr Stevens indicated to the Committee that the witnesses, Colleague A, Natalie Shaw, Valerie Shepherd and the expert Mr Kramer, were available to give oral evidence to the Committee. However, the GDC had no questions for these witnesses, but would tender them if the Committee had any questions for them. If not, Mr Stevens proposed that the witness statements should be taken as their oral evidence, and that this therefore would not be a situation of the GDC seeking to adduce hearsay evidence, necessitating a ruling from the Committee. The Committee agreed with this approach and indicated that it had no questions for Colleague A, Natalie Shaw, and Valerie Shepherd, and was content for their evidence to be confined to their witness statements. It did however have questions for Mr Kramer, and therefore required Mr Stevens to tender him.

33. The evidence provided to the Committee by the GDC was both documentary and oral. The documentary evidence comprised of:

- Signed witness statements and associated exhibits of Colleague A
- Signed witness statements and associated exhibits of Natalie Shaw, GDC Casework Manager
- Signed witness statements and associated exhibits of Valerie Shepherd, Senior Hearings Manager at the Dental Professionals Hearings Service ("DPHS")
- Signed Expert report and appendices of Mr Kramer
- Patient Records for Patients 1-15

34. Mr Kramer, the expert witness, gave oral evidence at the hearing.

35. The Committee received no documentary evidence or written submissions from Mr Gamba in response to the allegations.

The Committee's findings of fact

36. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Mr Stevens on behalf of the GDC.

37. The Committee accepted the advice of the Legal Adviser, including in relation to the burden and standard of proof, the need to consider the alleged matters separately, the need to have regard to the specific wording of each allegation, and how to approach the evidence.

38. In making its findings on the facts, the Committee bore in mind that the burden of proof rests with the GDC. There was no requirement for Mr Gamba to prove anything. Also, that the standard of proof is the civil standard, that is, whether the alleged facts are proved on the balance of probabilities. The Committee has had to decide whether it is more likely than not that the alleged matters are proved.

39. The Committee considered each head of charge separately and made the following findings:

"That being a registered dentist,	
A	You practised as a dentist at the dental practice referred to in Schedule 1 below ("the Practice") and treated the patients listed below (and referred to in Schedule 1 below). **Found proved** The Committee considered that there was factual evidence before it that Mr Gamba was a dentist at the Practice during the period specified and treated the patients in schedule 1. The Committee noted clinical records in which 15 patients were listed as having being treated by William Gamba. Colleague A's witness statement and associated exhibits also confirmed that Mr Gamba was a dentist at the Practice by way of her signed statement and the attached associate contract. The Committee accordingly was satisfied that the evidence upon which this charge was based was sufficient to find this charge proved.
Treatment and Record Keeping Failures	
B	*You failed to provide an adequate standard of care, with regard to treatment and record keeping, from 30 October 2020 to 22 May 2024, for Patients 1 to 15, in that:* In relation to charge B in its entirety, the Committee noted Mr Stevens' submissions that the Committee have received the full records, and was satisfied that it had sight of the full patient records before it for each of the 15 patients. It was satisfied that these records relate to patients 1-15 in regard to the relevant dates of 30 October 2020 to 22 May 2024. The Committee noted that each of the 41 allegations under B, are particulars of the stem of charge B, namely of a failure to provide an adequate standard of care regarding treatment and record keeping. The Committee therefore considered the matter of whether Mr Gamba had a duty as a dental professional to provide an adequate standard of care in relation to treatment and record keeping. It noted that the standards for dental professionals, focusing specifically on the following:

	• Standard 4.1 - *'You must make and keep contemporaneous, complete and accurate patient records'* • Standard 6.5 - *'You must communicate clearly and effectively with other team members and colleagues in the interests of patients'* • Standard 7.1- '*You must provide good quality care based on current evidence and authoritative guidance'* • Standard 7.2- *'You must work within your knowledge, skills, professional competence and abilities'* • Standard 7.3 – *'You must update and develop your professional knowledge and skills throughout your working life'* The Committee was satisfied therefore that Mr Gamba had a duty as a dental professional to provide an adequate standard of care in relation to treatment and record keeping. The Committee, satisfied that it had the all of the patients' records before it, and having concluded that Mr Gamba had the duty to provide an adequate standard of care, proceeded to make decisions on the specific alleged failures in relation to treatment and record keeping between 30 October 2020 and 22 May 2024 in relation to the 15 Patients. The Committee bore in mind Mr Gamba's duty to provide an adequate standard of care for each of these. These are detailed individually below.
Patient 1	
B1	During an appointment on 28 February 2022:
B1a	you carried out RCT on Patient 1's LR6 without using a rubber dam; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 1 attending an appointment on 28 February 2022, and that Mr Gamba was the treating dentist. The Committee noted that there was no record in the notes that a dental rubber dam was used by Mr Gamba when conducting a Root Canal Treatment (RCT). Mr Kramer's expert opinion is that there is no evidence that a rubber dam was used during root canal treatment as there is no rubber dam clamp opacity visible on the radiograph. The Committee noted from the copies of Patient 1's radiographs included within the clinical records, that there was no evidence of a dental dam clamp within these radiographic images. Mr Kramer's expert opinion is that a dental rubber dam is necessary as a *'Rubber dam is used to prevent bacterial ingress into the root canals via*

	contamination with saliva and also to reduce the risk of the patient swallowing or inhaling an instrument that is inadvertently dislodged. Because of the risks associated with not using rubber dam, it is my opinion that failing to do so was far below the standard expected'. The Committee accepted Mr Kramer's opinion, which he stated was underpinned by British Endodontic Society Guidelines. Given the absence of a record of a dental rubber dam, and a radiograph showing no clamp for a rubber dam, the Committee was satisfied on the balance of probabilities that a RCT was carried out without a rubber dam. It accepted Mr Kramer's opinion that this amounted to an inadequate standard of care. Accordingly, the Committee found this charge proved.
B1b	you did not take a post-operative radiograph, covering Patient 1's LR6, **Found Proved** As in charge B1a, the Committee had regard to the clinical records and noted that there is a record of Patient 1 attending an appointment on 28 February 2022, and that Mr Gamba was the treating dentist. The Committee reviewed the records and found no evidence of a post operative radiograph covering Patient 1's LR6. The Committee noted that there was no evidence of a post-operative radiograph within the clinical records, a fact which was confirmed by Mr Kramer following his analysis of the information. It also accepted Mr Kramer's oral evidence which he stated was underpinned by British Endodontic Society Guidelines, and he informed the Committee that there is an expectation that a dentist would take a post-operative radiograph following RCT. The Committee therefore concluded that given the absence of a post-operative radiograph in the records, Mr Gamba failed to provide an adequate standard of treatment, and accordingly found this charge proved.
B2	*You did not record:*
B2a	any details of your examination findings on 1 February 2022; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 1 attending an appointment on 1 February 2022, and that Mr Gamba was the treating dentist. The Committee noted that there were no details in the clinical records provided to it, in that there was no record other than that an appointment took place.

	The Committee accepted the opinion of Mr Kramer that there were no details of an examination and that this fell far below the standard expected. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of record keeping and accordingly found this charge proved.
B2b	sufficient details of the treatment you provided on
B2bi	28 February 2022; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 1 attending an appointment on 28 February 2022, and that Mr Gamba was the treating dentist. The Committee noted that there were insufficient details in the clinical records provided to it, in that there was no record other than that an appointment took place. The Committee accepted the opinion of Mr Kramer that there were no details of examination and the treatment Mr Gamba provided, and that this fell far below the standard expected. The Committee therefore concluded that given the absence of sufficient details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B2bii	31 August 2023; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 1 attending an appointment on 31 August 2023, and that Mr Gamba was the treating dentist. For the same reasons as in B2bi above, the Committee found this charge proved.
B2c	Details of the local anaesthetic you used during root canal treatment on 28 February 2022. **Found Proved** As in B1a and B1b above, the Committee had evidence before it of an appointment on this date and that Mr Gamba was the treating dentist.

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	The Committee noted however that there was no note on the clinical records provided whether a local anesthetic was used, and if so, the details of this. The Committee accepted the expert opinion of Mr Kramer in which he stated that *'it is probable that local anaesthetic was used to facilitate the treatment without pain. If local anaesthetic was used, a note in that regard detailing the type of anaesthetic and the site of administration should have been made in the records. Because of the risk of an adverse reaction to the anaesthetic, it would be important for a subsequent reader of the records to know what was used that caused any adverse reaction. Failing to record the details of any local anaesthetic used was far below the standard expected.'* The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of record keeping and accordingly found this charge proved.
B3	You did not report on radiographs taken on:
B3a	1 February 2022; **Found Proved** The Committee had regard to the clinical records and noted that radiographs of Patient 1's teeth were present in the clinical records dated 1 February 2022 and 28 February 2022, and that Mr Gamba was the treating dentist. The Committee had sight of the radiographs, however it noted from the records that is no evidence of any reports regarding the radiographs taken on these dates. The Committee accepted Mr Kramer's expert opinion that there was a duty to report on any radiographs taken and that failing to do so was a breach of the relevant Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). He also opined that a '*dental professional has a duty to comply* *with any regulations in place and failing to do so represents a lack of appropriate professionalism'.* The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure a safe continuity of care by subsequent treating dental professionals. Therefore, in the circumstances, the Committee determined that the failure to report on the radiographs taken represented a failure to provide

	adequate standards of care in relation to record keeping. Accordingly, it found this charge proved.
B3b	28 February 2022. **Found proved** For the reasons set out in B3a above.
Patient 2	
B4	You did not take a medical history and/or medical history update for Patient 2 on 25 January 2022. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 2 attending an appointment on 25 January 2022, and that Mr Gamba was the treating dentist. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee noted from the clinical records that the last recorded medical histories were dated 2017 and 2020, which far precedes the appointment 25 January 2022. The Committee accepted the advice of the Mr Kramer that failing to take and/or update a medical history falls far below the standard expected as a *'patient's medical history can have an impact on their dental health and any treatment that might be required'.* Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly it found this charge proved.
B5	You did not record:
B5a	any details of your examination findings and/or sufficient details of the treatment you provided on 25 January 2022; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 2 attending an appointment on 25 January 2022, and that Mr Gamba was the treating dentist. There was no record other than that an appointment took place and a tooth was treated.

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	The Committee accepted the opinion of Mr Kramer that there were no details of the findings of the examination and that there were insufficient details of the treatment provided, and that this fell far below the standard expected. The Committee was therefore satisfied that Mr Gamba failed to provide an adequate standard care in relation to record keeping, and accordingly found this charge proved.
B5b	any details of your examination findings on 8 August 2023; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 2 attending an appointment on 8 August 2023, and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care by subsequent treating dental professionals. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination, and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping, and accordingly found this charge proved.
B6	You did not report on radiographs taken on 25 January 2022. **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 2 attending an appointment on 25 January 2022, and that Mr Gamba was the treating dentist. As detailed in B3a above, there was duty for Mr Gamba to report on radiographs. The Committee noted that there was reference to radiographs within the clinical records and that it had sight of 2 radiographs that were taken. The Committee however noted that there was no record of a report within the clinical records. The Committee accepted Mr Kramer's opinion that failing to report on radiographs breached IRMER 17 guidelines. The Committee also

	concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care, by subsequent treating dental care professionals. The Committee was therefore content that the failure to report represented a failure to provide adequate standards of care in record keeping. Accordingly, it found this charge proved.
Patient 3	
B7	You did not take any bitewing radiographs during an appointment on 30 October 2020 or 29 July 2021. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 3 attending an appointment on 30 October 2020 and 29 July 2021, and that Mr Gamba was the treating dentist. The Committee noted that there is no record of any bitewing radiographs having been taken at either of these appointments. The Committee accepted Mr Kramer's expert opinion in oral evidence that bitewing radiographs, though should to be tailored to the appropriate dental risk, should be taken every 18 months to 2 years as a general rule. It also accepted his report in which he stated- *'Assuming that no other bitewing radiographs were taken between then and 30.10.2020, it is my opinion that then they should have been taken at the time of examination on 30.10.2020 and if not then on 29.07.2021. Failing to take the required radiographs meant that the Registrant was not well placed to be able to diagnose the presence of any caries and/or defective restorations on the approximal surfaces of the posterior teeth that could not be detected by clinical examination alone. Neither would the Registrant have been able to determine the periodontal bone levels that are indicative of the Patient's periodontal status. Failing to take the appropriate radiographs was, in my opinion, far below the standard of care expected.'* The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B8	You did not record any details of your examination findings on:
B8a	30 October 2020; **Found Proved**

	The Committee had regard to the clinical records and noted that there is a record of Patient 3 attending an appointment on 30 October 2020, and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B8b	29 July 2021. **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 3 attending an appointment on 29 July 2021, and that Mr Gamba was the treating dentist. The Committee noted that there was only one small detail in relation to the examination in the clinical records on this date. This read as follows- *'Notediscussion of long term approach to 47. PT is inclined not to undergo a complexrestoration and does not want it removed at this stage. KUIO.'* The Committee did not consider there to be any details on examination findings thesmlves, only a record of a discussion. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
Patient 4	
B9	You did not take a medical history and/or medical history update for Patient 4 on:
B9a	31 March 2021; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 4 attending an appointment on 31 March 2021, 28

	February 2022, and 26 January 2023, and that Mr Gamba was the treating dentist. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee noted from the clinical records that the last recorded medical history was dated May 2016, and that there had been no update since. The Committee accepted the advice of the Mr Kramer that failing to take and/or update a medical history falls far below the standard expected as a *'patient's medical history can have an impact on their dental health and any treatment that might be required'.* Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly it found this charge proved.
B9b	28 February 2022; **Found proved** As detailed in charge B9a above.
B9c	26 January 2023. **Found proved** For the reasons detailed in charge B9a above.
B10	You did not take any bitewing radiographs during an appointment on 31 March 2021 or 28 February 2022 or 26 January 2023. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 4 attending an appointment on 31 March 2021, 28 February 2022, and 26 January 2023, and that Mr Gamba was the treating dentist. The Committee noted that that there was no evidence of any bitewing Radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to taking radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken since 3/5/2016. His report stated that *'It is my opinion that having not taken bitewing radiographs on 31.03.2021, the Registrant should have taken them on 28.02.2022 and if not then, 26.01.2023.'* Mr

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	Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing Radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B11	You did not record any details of your examination findings on:
B11a	31 March 2021; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 4 attending an appointment on 31 March 2021, 28 February 2022, and 26 January 2023, and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care, by subsequent treating dental care professionals. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B11b	28 February 2022; **Found Proved** For the reasons detailed in B11a above.
B11c	26 January 2023. **Found Proved** For the reasons detailed in B11a above.

Patient 5	
B12	You did not take a medical history and/or medical history update for Patient 5 on:
B12a	20 November 2020; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 5 attending appointments on 20 November 2020, 19 May 2021, 18 October 2021, 12 May 2022, 11 January 2023, 5 July 2023 and that Mr Gamba was the treating dentist. The Committee noted from the clinical records that there was no record of Mr Gamba taking or updating medical histories on any of the above dates. The Committee noted in Patient 5's records that a medical review was noted on 19 August 2020 and 5 April 2022, and these details were recorded when the patient was seen by other practitioners. The Committee was satisfied that medical history updates by other practitioners did not negate the obligation on Mr Gamba to undertake them. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee accepted the advice of the Mr Kramer that failing to take and/or update a medical history falls far below the standard expected (for the same reasons he outlined for charge B9a). Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly it found this charge proved.
B12b	19 May 2021; **Found Proved** For the reasons detailed in B12a above.
B12c	18 October 2021; **Found Proved** For the reasons detailed in B12a above.
B12d	12 May 2022; **Found Proved**

	For the reasons detailed in B12a above.
B12e	11 January 2023; **Found Proved** For the reasons detailed in B12a above.
B12f	5 July 2023. **Found Proved** For the reasons detailed in B12a above.
B13	You did not take any bitewing radiographs during an appointment on 20 November 2020 or 19 May 2021. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 5 attending an appointment on 20 November 2020 and 19 May 2021 and that Mr Gamba was the treating dentist. The Committee noted that that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to taking radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken. Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B14	You did not record any details of your examination findings on:
B14a	19 May 2021; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 5 attending an appointment on 19 May 2021, 3

	February 2022, 11 January 2023, and 5 July 2023 and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and the safe continuity of care, by subsequent treating dental care professionals. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B14b	3 February 2022; **Found Proved** For the reasons detailed in B14a above.
B14c	11 January 2023; **Found Proved** For the reasons detailed in B14a above.
B14d	5 July 2023. **Found Proved** For the reasons detailed in B14a above.
Patient 6	
B15	You did not take a medical history and/or medical history update for Patient 6 on:
B15a	16 May 2023; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 6 attending appointments on 16 May 2023 and 12 June 2023, and that Mr Gamba was the treating dentist.

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	The Committee noted from the clinical records that there was no record of Mr Gamba for taking or updating a medical history. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee accepted the opinion of Mr Kramer that failing to take and/or update a medical history falls far below the standard expected, and that it would have been especially important given that the plan was to extract this Patient's LL7 and UR8. Mr Kramer's opinion is that medical conditions and medications can have an effect on the extraction process and how it should be managed and how aftercare should be provided and therefore the medical update was important. The Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly, it found this charge proved.
B15b	12 June 2023. **Found proved** For the reasons detailed at charge B15a above.
B16	During an appointment on 3 July 2023, you inappropriately provided a filling including the distal aspect of Patient 6's LR5. **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 6 attending an appointment on 3 July 2023, and that Mr Gamba was the treating dentist. The records show that Mr Gamba did provide a filling to LR5 at this appointment. The Committee accepted the expert opinion of Mr Kramer. He stated that- *'The record for 03.07.2023 indicates that a mesial-occlusal-distal filling was provided (MDO). If that was the case, it is my opinion it was inappropriate treatment because the 12.06.2023 radiograph shows a radiolucency confined to the mesial aspect of LR5 consistent with there being caries in that surface and under the occlusal surface. Hence the filling required was only a mesio-occlusal (MO). If the distal aspect of the tooth was treated, it is my opinion that the standard of care was far below that expected because unnecessary treatment was provided with consequent harm by way of avoidably removing sound tooth substance'.* The Committee accepted Mr Kramer's opinion that this filling was inappropriate.

	Therefore, the Committee determined that Mr Gamba had failed to provide an adequate standard of care in his treatment of the patient when providing a filling. The Committee accordingly found this charge proved.
B17	You did not record:
B17a	any details of your examination findings on 12 June 2023; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 6 attending an appointment on 12 June 2023 and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B17b	details of the local anaesthetic you used during an appointment on:
B17bi	16 May 2023; **Found proved** The Committee noted Patient 6's attendance and Mr Gamba's role as treating dentist as at charge B15 above. The Committee noted that there was no reference to local anaesthetic at all within the clinical records. The Committee was satisfied that a three surface filling was provided, as indicated in the clinical records. Whilst such a filling can be undertaken without an anaesthetic, given its size, the Committee considered that it was more likely than not that a local anaesthetic would have been used for such a filling. It therefore should have been recorded in the clinical notes.

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	The Committee accepted Mr Kramer's expert opinion that failing to record details of local anaesthetic indicates a standard of record keeping that falls far below the standards expected. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in his record keeping and accordingly the Committee found this charge proved.
B17bii	12 June 2023; **This charge was withdrawn on the application of Mr Stevens, following Mr Kramer's evidence. The withdrawal was acceded to by the Committee.**
B17biii	3 July 2023. **Found Proved** For the reasons detailed in charge B17bi above.
B18	You did not report on radiographs taken on:
B18a	16 May 2023; **Found proved** The Committee was satisfied from the clinical records that radiographs were taken at appointments on 16 May 2023 and 12 June 2023, and that the treating Dentist was Mr Gamba. The Committee had sight of the radiographs. The Committee however noted that there are no reports within the clinical records for any of these radiographs. The Committee accepted Mr Kramer's expert opinion that Mr Gamba did not report on the radiographs provided and that (as previously detailed at charge B3a) failing to report on a radiograph is a breach of the IRMER 17 regulations. The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded you failed to provide an adequate standard of care in relation to record keeping. The Committee accordingly found this charge proved.
B18b	12 June 2023.

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	Found proved For the reasons detailed in charge B18a above.
Patient 7	
B19	You did not take any bitewing radiographs during an appointment on 27 September 2022. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 7 attending an appointment on 27 September 2022 and that Mr Gamba was the treating dentist. The Committee noted that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to the need to take bitewing radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at this appointment, when they should have been, given that no other dentist had taken any in the previous year. Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on this date, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B20	You did not record:
B20a	any details of your examination findings on 27 September 2022; **Found Proved** The patient attended an appointment on 27 September 2022 and was treated by Mr Gamba, as detailed in charge B19 above. The Committee noted that there was no detail regarding examination findings in the clinical records. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an

	examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B20b	details of the local anaesthetic you used during an appointment on 27 September 2022. **Found proved** The Committee noted Patient 7's attendance and Mr Gamba's role as treating dentist as at charge B20a above. The Committee noted that there was no reference to local anaesthetic at all within the clinical records. The Committee was satisfied that a two surface filling was provided to the UR6, as indicated in the clinical records. Whilst such a filling can be undertaken without an anaesthetic, given its size, the Committee considered that it was more likely than not that a local anaesthetic would have been used for such a filling. It therefore should have been recorded in the clinical notes. The Committee accepted Mr Kramer's expert opinion that there was a failure to note what, if any, local anesthetic was used and that this indicates a standard of record keeping that falls far below the standards expected. The Committee therefore concluded that given the absence of any details in the records of local anaesthetic, Mr Gamba failed to provide an adequate standard of care in his record keeping and accordingly found this charge proved.
B21	You did not report on a radiograph taken on 27 October 2022 **Found proved** The Committee was satisfied from the clinical records that a radiograph was taken at the appointment on 27 October 2022, and that the treating dentist was Mr Gamba. The Committee had sight of the radiograph. The Committee however noted that there is no report within the clinical records for this radiograph. The Committee accepted Mr Kramer's expert opinion that Mr Gamba did not report on the radiograph provided and that (as previously detailed at charge B3a) failing to report on a radiograph is a breach of the IRMER 17 regulations.

	The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded you failed to provide an adequate standard of care in relation to record keeping. The Committee accordingly found this charge proved.
Patient 8	
B22	During an appointment on 30 January 2023, you prescribed antibiotics without an appropriate clinical justification. **Found Proved** The Committee noted from the clinical records that there was an appointment on 30 January 2023, which Patient 8 attended, and the treating Dentist was Mr Gamba. The Committee noted that there was a record of an examination, a radiograph, and a prescription at this appointment. The Committee noted however that there were no further details provided in the clinical record, in that there was no record of an infection, a diagnosis, or any issues that arose from the examination that would suggest a requirement of antibiotics. The Committee accepted the opinion of Mr Kramer that '*If there was no spreading infection and/or no reason why treatment could not to be provided, then antibiotics should not have been prescribed'.* The Committee also took into consideration Mr Kramer's oral evidence in which he referred the Committee to the College of Dentistry guidelines on prescribing antibiotics, and explained the risk of resistance from over prescribing. The Committee determined that appropriate clinical justification is important when prescribing antibiotics. In prescribing antibiotics without an appropriate clinical justification, and in failing to record any justification, Mr Gamba failed to provide an adequate standard of care in relation to treatment and record keeping. Accordingly, the Committee found this charge proved.
B23	During an appointment on 17 February 2023 you carried out RCT on Patient 8's LL5 without using a rubber dam; **Found proved**

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	The Committee had regard to the clinical records and noted that there is a record of Patient 7 attending an appointment on 17 February 2023 and that Mr Gamba was the treating dentist. The Committee noted that 3 radiographs were taken on this day, which is consistent with an RCT being undertaken. Whilst it noted that the appointment history listed the appointment as having taken place then later as being cancelled, the presence of the periapical radiographs satisfied the Committee that the appointment did take place on this date. The Committee noted that there was no record or detail within the clinical notes about the use of a rubber dam during the RCT procedure. The Committee accepted the advice of Mr Kramer whose analysis is that no rubber dam was used during the RCT due to the lack of any evidence of one being used, either in the records or in the radiographs which would have shown the rubber dam clamp. Mr Kramer's opinion was underpinned by the British Endodontic Society guidelines. The Committee therefore considered that it was more likely than not that no rubber dam was used. The Committee also accepted Mr Kramer's explanation as to why a rubber dam is important to use when conducting a RCT. He stated a *'rubber dam is used to prevent bacterial ingress into the root canals via contamination with saliva and also to reduce the risk of the patient swallowing or inhaling an instrument that is inadvertently dislodged.'* The Committee considered that in not using a rubber dam, Patient 8 was put at risk of the above issues. The Committee therefore determined that due to the risks associated there is a breach of standard of care in not using the rubber dam. It concluded that Mr Gamba provided an inadequate standard of care in terms of treatment and therefore find this charge proved.
B24	You did not record:
B24a	any details of your examination findings and/or any details of Patient 8's presenting complaint on 30 January 2023; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 8 attending an appointment on 30 January 2023, and that Mr Gamba was the treating Dentist. The Committee noted that the records for these appointments were sparse. It noted that there was a record of an examination, radiographs, and a prescription in the clinical records but that there were no details at all on the findings nor details on Patient 8's presenting complaint. The

	Committee noted that there was no detail at all as to which tooth was causing Patient 8 issues. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination nor Patient 8's presenting complaint, and that this fell far below the standard expected for record keeping. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care, by subsequent treating dental care professionals. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B24b	sufficient details of the treatment you provided on:
B24bi	17 February 2023; **Found Proved** The Committee had sight of the clinical records and noted that there is a record of Patient 8 attending an appointment on 17 February 2023 and 24 March 2023, and that Mr Gamba was the treating Dentist. The Committee noted that there were insufficient details in the clinical records provided to it, in that there were no further details in the record other than that an appointment took place. The Committee accepted the opinion of Mr Kramer that there was a failure to note any details relating to the treatment provided, and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B24bii	24 March 2023; **Found Proved** For the reasons detailed at charge B24bi.

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B24c	details of the local anaesthetic you used during an appointment on:
B24ci	17 February 2023; **Found Proved** The Committee noted Patient 8's attendance and Mr Gamba's role as treating dentist as at charge B24a above. The Committee noted that there was no reference to local anaesthetic at all within the clinical records. Given that the treatment was a RCT on the LL5, the Committee concluded that on the balance of probabilities, it was more likely than not that local anaesthetic was used for this treatment. The Committee accepted Mr Kramer's expert opinion that there was a failure to note what, if any, local anesthetic was used and that this indicates a standard of record keeping that falls far below the standards expected. The Committee therefore concluded that given the absence of any details in the records of local anaesthetic, Mr Gamba failed to provide an adequate standard of care in his record keeping and accordingly found this charge proved.
B24cii	24 March 2023; **Found Proved** For the reasons detailed at charge B24ci.
B24d	any details of when Patient 8's LL5 was prepared for the crown that was fitted on 24 March 2023. **Found Proved** The Committee noted from the clinical records that a crown was placed on Patient 8's LL5 on 24 March 2023 by Mr Gamba. The Committee took into consideration Mr Kramer expert opinion that preparations should have been done 2 weeks beforehand. He stated that *'If a crown was fitted on 24.03.2023, there is no note as to when LL5 was prepared. This should have happened approximately two weeks prior to fitting.'* The Committee accepted this opinion. It assessed the clinical records and, noting that it had all of the records before it, determined that there is no record of an appointment 2 weeks before in which Patient 8's LL5 was prepared for a crown to be fitted. The

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	Committee noted that in fact there was no clinical record at all of an appointment in which the LL5 was prepared for a crown fitting. The Committee noted the opinion of Mr Kramer that the matter should have been recorded and it concluded that its absence constituted both a failure to provide adequate care in terms of treatment and represented a failure in accurate record keeping. Accordingly, the Committee found this charge proved.
B25	You did not report on radiographs taken on:
B25a	30 January 2023; **Found Proved** The Committee was satisfied from the clinical records that radiographs were taken at appointments on 30 January 2023, 17 February 2023, and 22 June 2023, and that the treating dentist was Mr Gamba. The Committee had sight of the radiographs. The Committee however noted that there are no reports within the clinical records for any of these radiographs. The Committee accepted Mr Kramer's expert opinion that (as previously detailed at charge B3a) failing to report on a radiograph is a breach of the IRMER 17 regulations. The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded you failed to provide an adequate standard of care in relation to record keeping. The Committee accordingly found this charge proved.
B25b	17 February 2023; **Found proved** For the reasons detailed in charge B25a above.
B25c	22 June 2023. **Found proved** For the reasons detailed in charge B25a above.
Patient 9	

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B26	You did not take a medical history and/or medical history update for Patient 9 on:
B26a	28 April 2021; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of patient 9 attending an appointment on 28 April 2021 and 30 January 2023, and that Mr Gamba was the treating dentist. The Committee noted from the clinical records that there was no record of Mr Gamba taking or updating a medical history. The Committee noted from patient 9' records that the only medical update is dated 11 March 2025. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee accepted the opinion of Mr Kramer that there was no evidence of a medical history/medical history update being taken at these appointments and that this falls far below the standard expected. Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly, it found this charge proved.
B26b	30 January 2023. **Found Proved** For the reasons detailed at charge B26a above.
B27	You did not record sufficient details of your examination findings on:
B27a	28 April 2021; **Found Proved** The Committee had sight of the clinical records and noted that there is a record of Patient 9 attending an appointment on 28 April 2021 and 30 January 2023, and that Mr Gamba was the treating dentist. The Committee noted that there were insufficient details in the clinical records provided to it, in that there were no further details in the record other than that an appointment took place and a base chart was carried out. The Committee determined that the base chart alone did not provide sufficient details.

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	The Committee accepted the opinion of Mr Kramer that there was a failure to note sufficient detail relating to the treatment provided, and that this fell far below the standard expected for record keeping. He stated that there was some detail, in that some of the primary teeth had been exfoliated, but that detail was insufficient. The Committee therefore concluded that given the absence of sufficient detail in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B27b	30 January 2023. **Found Proved** For the reasons detailed at charge B27a above.
Patient 10	
B28	During an appointment on 24 October 2022, you did not take:
B28a	any bitewing radiographs; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 10 attending an appointment on 24 October 2024 and that Mr Gamba was the treating dentist. The Committee noted that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to the need to take bitewing radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at this appointments, when they should have been, given that no other dentist had taken any in the previous year. Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected, as *'failing to take the appropriate radiographs would have meant that the Registrant was not well placed to be able to determine whether there was any caries developing in the surfaces of the teeth that could not be seen by clinical examination alone'.* The Committee accepted this opinion.

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	The Committee was satisfied that in not taking bitewing radiographs on this date, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B28b	a medical history and/or medical history update for Patient 10. **Found Proved** The Committee was satisfied as in B28a that the Patient attended on this date and was treated by Mr Gamba. The Committee noted from the clinical records that there was no record of Mr Gamba taking or updating a medical history. The Committee noted from Patient 10's records that a medical update had not been taken since 2007. In 2020 there was an update to the details of the registered medical practitioner, however there were no further details updated. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee accepted the advice of the Mr Kramer that failing to take and/or update a medical history falls far below the standard expected (for the same reasons he outlined for charge B9a). Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly it found this charge proved.
B29	You did not record sufficient details of your examination findings on 24 October 2022. **Found proved** The Committee was satisfied as in B28a that the Patient attended on this date and was treated by Mr Gamba. The Committee noted that there were insufficient details in the clinical records provided to it, in that there was no further details in the record other than that an appointment took place. The Committee accepted the opinion of Mr Kramer that there was a failure to note sufficient detail relating to the treatment provided by only recording attendance, and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of sufficient details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.

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Patient 11	
B30	You did not take a medical history and/or medical history update for Patient 11 on:
B30a	19 January 2021; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 10 attending an appointment on 19 January 2021 and 10 May 2023, and that Mr Gamba was the treating dentist. The Committee noted from the clinical records that there was no record of Mr Gamba taking or updating a medical history on either dates. The Committee noted from Patient 10's records that a medical update had not been taken since 2017. In 2022 and 2024 there is evidence of medical history updates, but these correspond to different dental professionals providing treatment. The Committee noted that whilst a different practitioner had taken a medical history in 2022, this did not negate Mr Gamba's obligation to take a medical history in 2021 and 2023. The Committee considered that taking a medical history is a fundamental aspect of providing safe and effective dental care. The Committee accepted the advice of the Mr Kramer that there is no record of a medical history/medical history updated being that and that failing to do so falls far below the standard expected. Therefore, the Committee concluded that the failure to do so provided an inadequate standard of care in relation to treatment and record keeping. Accordingly it found this charge proved.
B30b	10 May 2023; **Found Proved** For the reasons detailed at B30a above.
B31	You did not take any bitewing radiographs during an appointment on 10 May 2023 or 22 May 2024. **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 11 attending an appointment on 10 May 2023 and 22 May 2024 and that Mr Gamba was the treating dentist.

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	The Committee noted that that there was no evidence of any bitewing radiograph in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to the need to take bitewing radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at these appointments, when they should have been, Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B32	You did not record any details of your examination findings on:
B32a	19 January 2021. **Found not proved** The Committee had regard to the clinical records and noted that there is a record of Patient 11 attending an appointment on 19 January 2021 and that Mr Gamba was the treating dentist. The Committee noted that there were some details of the examination in the clinical records. It noted that Mr Gamba completed a base chart and noted within the clinical records that there was some staining on the teeth. The Committee considered that a base chart forms a part of the overall clinical examination, and so any findings noted within this are evidence of examination findings. Whilst the Committee did not consider the records to be fully detailed and to the standard expected, it was satisfied that there was some evidence of examination findings given that there were clinical notes that referred to stained teeth. This charge alleges that Mr Gamba did not record <u>any</u> details of examination findings. However, the Committee noted that the records show a partially completed base chart and that Mr Gamba had noted there was intrinsic staining on the patient's teeth. These are examination findings. As the GDC has not made an allegation of insufficient details (as it did in relation to other charges) the Committee was not satisfied that the GDC has proved the allegation as drafted. The Committee therefore found this charge not proved.
Patient 12	
B33	During an appointment on 31 May 2023, you:

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B33a	did not take any bitewing radiographs; **Found proved** The Committee had regard to the clinical records and noted that there is a record of Patient 12 attending an appointment on 31 May 2023, and that Mr Gamba was the treating dentist. The Committee noted that that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to taking radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at these appointments, when they should have been given that none had been taken in the previous year. Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B33b	took a radiograph covering Patient 12's upper molar teeth, without appropriate clinical justification. **Found proved** The Committee was satisfied as in charge 33a there was an appointment on this day, which the Patient attended, and the treating dentist was Mr Gamba. The Committee noted from the clinical records that there is evidence of a periapical radiograph taken on this date. However, the Committee noted that there was no log, justification, or record within the clinical records for this radiograph. Mr Kramer's expert opinion stated that-'*The records contain one radiograph showing upper molar teeth. I am informed that the radiograph was taken on 31.05.2023. It is unclear why it was taken. If the radiograph was taken without justification, the standard of care was far below that expected, because the relevant regulations (IR(ME)R 2017) state that all radiographs must be justified so that radiation exposure can be kept to a minimum.*' The Committee accepted Mr Kramer's opinion that there was a risk to patients in breaching IRMER guidelines. The absence of a recorded justification led the Committee to determine that there was not an appropriate clinical justification for taking this radiograph. It therefore concluded that this was an inadequate standard

	of care in relation to both treatment and record keeping. The Committee accordingly found this charge proved.
B33c	Did not report on a radiograph taken. **Found Proved** The Committee was satisfied from the clinical records that a radiograph was taken at this appointment and that it had sight of this, and that the treating Dentist was Mr Gamba. The Committee however noted that there is no report of this radiograph included within the clinical records. The Committee accepted Mr Kramer's expert opinion that (as previously detailed at charge B3a) failing to report on a radiograph is a breach of the IRMER 17 regulations. The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded you failed to provide an adequate standard of care in relation to record keeping. The Committee accordingly found this charge proved.
B34	You did not record any details of your examination findings on 31 May 2023. **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 12 attending an appointment on 31 May 2023 and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care, by subsequent treating dental care professionals. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
Patient 13	

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B35	You did not take any bitewing radiographs during an appointment on:
B35a	5 November 2020; **Found Proved** The Committee considered charge 35 in its entirety. It noted that there was evidence of appointments on 5 November 2020, 5 May 2022, and 21 December 2022 in the clinical records, for which Patient 13 attended and was treated by Mr Gamba. The Committee noted that that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to taking radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at these appointments, when they should have been, Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B35b	5 May 2022; **Found Proved** As detailed at charge B35a above.
B35c	21 December 2022. **Found Proved** As detailed at charge B35a above.
B36	You did not record any details of your examination findings on:
B36a	5 November 2020; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 15 attending a appointment on 5 November 2020, 5

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	May 2022, and 21 December 2022 and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care by subsequent treating dental professionals. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B36b	5 May 2022; **Found Proved** As detailed in B36a above.
B36c	21 December 2022. **Found Proved** As detailed in B36a above.
Patient 14	
B37	During an appointment on 31 May 2023, you prescribed antibiotics without an appropriate clinical justification. **Found Proved** The Committee noted from the clinical records that there was an appointment on this day, which the Patient attended, and the treating Dentist was Mr Gamba. The Committee noted that there was a record of an examination, a radiograph, and a prescription at this appointment. The Committee noted however that there were no more details provided in the clinical record, in that there was no record of an infection, a diagnosis, or any issues that arose from the examination. The Committee accepted the opinion of Mr Kramer that *'there is nothing in the records to show that the Patient had any spreading infection or swelling that could not be treated by means of operative intervention and no diagnosis of*

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	infection was noted in the records. It is my opinion, that there is no evidence to show that there was any justification for prescribing antibiotics. If there was no indication for antibiotics to be prescribed the standard of care was far below that expected.' The Committee determined that appropriate clinical justification is important when prescribing antibiotics. In prescribing antibiotics without an appropriate clinical justification, and in failing to record any justification, Mr Gamba failed to provide an adequate standard of care in relation to treatment and record keeping. Accordingly, the Committee found this charge proved.
B38	For an appointment on 31 May 2023, you did not record:
B38a	Patient 14's presenting complaint; **Found Proved** The Committee considered charge B38 as a whole. The Committee noted that there was evidence of an appointment on 31 Mary 2023 in the clinical records, for which Patient 14 attended and was treated by Mr Gamba. The Committee noted that that there was nothing in the clinical records in relation to Patient 13's presenting complaint, the examination findings, nor a diagnosis. The Committee accepted Mr Kramer's expert opinion that these should have been recorded and therefore Mr Gamba's record keeping was far below the standard expected. The Committee therefore concluded that given the absence of any note in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B38b	any details of your examination findings; **Found Proved** As detailed in B38a above.
B38c	a diagnosis. **Found Proved** As detailed in B38a above.

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B39	You did not report on a radiograph taken on 31 May 2023; **Found Proved** The Committee was satisfied from the clinical records that a radiograph was taken at this appointment and that it had sight of this, and that the treating dentist was Mr Gamba. The Committee however noted that there is no report of this radiograph included within the clinical records. The Committee accepted Mr Kramer's expert opinion that (as previously detailed at charge B3a) failing to report on a radiograph is a breach of the IRMER 17 regulations. The Committee also concluded that reporting on radiographs was required because of the duty on practitioners to ensure the safe continuity of care by subsequent treating dental professionals. The Committee therefore concluded that this amounted to a failure to provide an adequate standard of care in relation to record keeping. The Committee accordingly found this charge proved.
Patient 15	
B40	You did not take any bitewing radiographs during an appointment on 12 January 2023. **Found Proved** The Committee noted that there was evidence of an appointment on 12 January November 2023 in the clinical records, for which Patient 15 attended and was treated by Mr Gamba. The Committee noted that that there was no evidence of any bitewing radiographs in the clinical records from these dates. The Committee accepted Mr Kramer's evidence in relation to taking radiographs every 18 months to two years, as detailed in charge B7 above. Mr Kramer's report also stated that no bitewing radiographs had been taken at these appointments, when they should have been, Mr Kramer opined that this failure to take appropriate radiographs meant that the standard of care was far below expected. The Committee accepted this opinion. The Committee was satisfied that in not taking bitewing radiographs on these dates, it represents an inadequate standard of care in relation to treatment. Accordingly, it found this charge proved.
B41	You did not record:

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B41a	any details of your examination findings on 12 January 2023; **Found Proved** The Committee had regard to the clinical records and noted that there is a record of Patient 15 attending an appointment on 12 January 2023 and that Mr Gamba was the treating dentist. The Committee noted that there was no detail regarding examination findings in the clinical records. It considered that providing details of an examination is required because of the duty on practitioners to ensure contemporaneous records and a safe continuity of care by subsequent treating dental professionals. The Committee accepted the opinion of Mr Kramer that there were no details regarding the findings of Mr Gamba's examination and that this fell far below the standard expected for record keeping. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in relation to record keeping and accordingly found this charge proved.
B41b	Details of the local anaesthetic you used during an appointment on 12 January 2023. **Found proved** The Committee noted Patient 15's attendance and Mr Gamba's role as treating Dentist as at charge B41a above. The Committee noted that there was no reference to local anaesthetic at all within the clinical records. The Committee considered that on the balance of probabilities, it was more likely than not that local anaesthetic was used for this treatment given that it was a two surface filling on the UL4. Therefore, this should have been recorded in the notes. The Committee noted that the only reference to this filling within the clinical records is that a composite filling was provided to the UL4 on this day. The Committee accepted Mr Kramer's expert opinion that failing to record details of local anesthetic indicates a standard of record keeping that falls far below the standards expected. The Committee therefore concluded that given the absence of any details in the records, Mr Gamba failed to provide an adequate standard of care in his treatment and record keeping and accordingly found this charge proved.

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Practising whilst Suspended	
C	Between 16 and 24 May 2024, you provided dental services whilst your General Dental Council registration was subject to an interim suspension order. **Found Proved** The Committee first considered whether Mr Gamba was subject to an interim suspension order on the relevant dates. The Committee had sight of the Interim Order Committee (IOC) review determination, dated 13 May 2026, in which the IOC determined that an interim order of suspension was necessary and revoked the previous order of conditions. The Committee noted that a letter was sent to Mr Gamba on 14 May 2024, via recorded delivery to his registered address and secure email to his registered email, informing him of the suspension. This confirmed that the suspension would take effect from 16 May 2024 (the notification date). The Committee accordingly was satisfied that an interim order of suspension was in place from that date. The Committee next considered whether Mr Gamba provided dental services during this time period. It noted Colleague A's witness statement in which she stated that she had seen Mr Gamba at the Practice on these dates, as she was also working on the dates in question. The Committee also noted that it had sight of a list of 93 patients from the Practice's computer system, who were noted as treated by Mr Gamba on these dates. The Committee accepted this evidence. The Committee was satisfied that the GDC had discharged its burden of proof in relation to this charge, and concluded that Mr Gamba did provide dental services between 16-24 May 2024, whilst subject to an interim suspension order. The Committee accordingly found this charge proved.
D	Your conduct in Charge C put patient safety at risk. **Found Proved** The Committee asked itself whether practicing whilst suspended put patient safety at risk. The Committee had regard to the risk assessment carried out by the IOC. The IOC imposed an interim suspension order primarily on the statutory ground of it being necessary to protect the public. It was the IOC's judgment *"that there would be a significant risk of harm to patients if Mr Gamba were permitted to return to unrestricted practise"* and that the only way to manage the risks was to impose an interim suspension order.

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	The Committee considered that it was self evident that where a registrant is suspended on the ground of it being necessary for public protection, in a clinical issues case, practising whilst suspended puts patient safety at risk. The Committee took this risk assessment into account and was further satisfied that by practising whilst suspended, Mr Gamba put patient safety at risk. This was because the clinical failings alleged at the time of Mr Gamba's suspension were wide-ranging failings of basic safe dental practice and, if repeated, would have put patients at risk. Indeed, the Committee has made a finding of fact in relation to Patient 11 and concluded that the treatment provided by Mr Gamba on 24 May 2024 amounted to a failure to provide an adequate standard of care. Accordingly, the Committee was satisfied that Mr Gamba continuing to practise whilst suspended put patient safety at risk. It therefore found this charge proved.
Failing to cooperate with the GDC	
E	From 21 November 2024 to 29 January 2025, you failed to cooperate with an investigation conducted by the General Dental Council in that you did not respond to the GDC's requests for information. **Found Proved** The Committee first considered whether Mr Gamba had the duty to cooperate with any GDC investigation. The Committee noted that standard 9.4.1 of the GDC's 'Standards for the Dental Team' (2013), states that *'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.'* The Committee considered that the 'letter' as stated in the standards was sent to Mr Gamba by both post and email on multiple occasions. The Committee was therefore satisfied that Mr Gamba had a duty to respond, and that it was not merely desirable that he do so. The Committee considered there to be reliable and cogent evidence from 2 GDC members of staff who provided witness statements and associated exhibits. Both witnesses confirmed in their statements that Mr Gamba did not respond to the GDC's requests for information. The Committee noted repeated attempts from the GDC to contact Mr Gamba, by way of emails, post, and telephone calls between 21 November 2024 and 29 January 2025. These repeated attempts are summarised below:

	• 14 November 2024– a letter was sent to Mr Gamba via email requesting information (including evidence of his indemnity) by 21 November 24 – Pages 273-283 – Tab C. • 20 December 2024- Mr Gamba emailed the GDC requesting that this letter be resent. • 3 January 2025 – the letter was re-sent to Mr Gamba via email. The letter requested a response by 10 January 2025. • 13 January 2025 – a further letter was sent via email requesting this information by 20 January 2025. This letter was also sent on the same day via signed for delivery. This was signed for by 'GAMBA' 14 January 25. No response was received. • 22 January 2025 – the GDC caseworker attempted to call Mr Gamba, He did not respond. • 22 January 25 –an email was sent to Mr Gamba requesting response by 29 January 2025. This email informed him that if no response was received by this date, the GDC would proceed with investigation on the basis that he does not wish to respond. He was reminded of Standard 9.4.1. He did not respond. The Committee noted that Mr Gamba's last communication with the GDC was on 20 December 2024. There was no evidence before it of Mr Gamba having communicated with the GDC since that date, nor provided any information to the GDC. The Committee was satisfied having considered the numerous repeated attempts of the GDC to communicate with Mr Gamba, that he did not respond to any of the requests for information. The Committee was therefore satisfied that Mr Gamba did not respond to the GDC's requests for information and that by not responding, he breached the duty to correspond with the GDC in relation to concerns about a registrant's fitness to practise. The Committee accordingly concluded that Mr Gamba failed to cooperate with an investigation by the GDC by way of not responding to requests for information, and therefore found this charge proved.

40. We move to stage two.

Stage 2 Determination

41. Following its announcement of its decision on the facts, the hearing moved to Stage 2. At Stage 2, the Committee considered whether the facts found proved amounted to misconduct or Deficient Professional Performance (DPP) (in relation to matters proved at charge B) and, if so, whether Mr Gamba's fitness to practise is currently impaired by reason of his misconduct or deficient professional performance. If it found that Mr

Gamba's fitness to practise is impaired, it would consider what sanction, if any, should be imposed.

Submissions

42. Mr Stevens first addressed the Committee in respect of your fitness to practise history, and confirmed that there had been no previous fitness to practise (ftp) matters.

43. Mr Stevens submitted on the statutory bases of misconduct and Deficient Professional Performance. He submitted that the GDC's primary position on charge B, was that the proved clinical failings amounted to misconduct. The Committee should only go on to consider DPP if it did not conclude that charge B amounted to misconduct.

44. Mr Stevens set out his submissions by separating the matters into 3 categories: clinical failings relating to charge B; practising whilst suspended in relation to charge C and D; and non-cooperation with the GDC investigation in regard to charge E.

45. Mr Stevens referred the Committee to the relevant case law and the GDC's *Standards for the Dental Team (2013).*

46. In relation to the clinical failings findings, Mr Stevens submitted that these related to basic and fundamental areas of dentistry. He submitted that the failings posed a real risk to patient safety, that were in no way inconsequential. He submitted by way of example, that Mr Gamba's failure to use a rubber dental dam whilst carrying out a RCT posed a real risk to patients' safety. He further exampled that by not taking or updating a medical history this could adversely affect the treatment that patients received. Mr Stevens also submitted that Mr Kramer had assessed the care provided by Mr Gamba to be far below the standard expected of a dental professional in relation to every clinical charge. Mr Stevens therefore submitted that the Committee could comfortably conclude that the findings in relation to the clinical failings amounted to misconduct which was serious.

47. If the Committee were not satisfied that charge B amounted to misconduct, Mr Stevens submitted that there was a fair sample of Mr Gamba's work with 15 patients, and that the standard of performance was unacceptably low. He therefore submitted that the Committee could find that the failings amounted to DPP.

48. Mr Stevens next referred to the failing in relation to Mr Gamba's adherence with his interim order and his practising whilst suspended. Mr Stevens submitted that the purpose of an interim order is protect the public and that there was a risk to the public's safety should a registrant not adhere to the order. Mr Stevens submitted that Mr Gamba's breach of the order designed to protect the public risked patient safety, and further submitted that this was not an isolated incident as Mr Gamba treated patients over many days. He submitted that there were ramifications to both patients and the public trust and confidence in the profession by Mr Gamba's breach of his suspension order. Mr Stevens submitted that there was no probity charge in relation to Mr Gamba's non-adherence, and therefore the matter of whether Mr Gamba was purposeful and dishonest in continuing to practise whilst suspended could not possibly be known. Nonetheless, he submitted that Mr Gamba's non-adherence was reckless. Mr Stevens

therefore submitted that breaching an important order designed to protect the public could properly be judged as misconduct.

49. Mr Stevens lastly referred to the third matter of non-cooperation with the GDC. Mr Stevens submitted that standard 9.4 of the GDC's standards refers to the duty to engage and cooperate with the GDC. Mr Stevens submitted that Mr Gamba's non-cooperation had wide ranging ramifications and did not just affect Mr Gamba's own individual reputation. Mr Stevens submitted that the non-cooperation frustrated the efficacy of the FtP process in that the GDC was left with unanswered questions that it could not investigate further. He also submitted that public confidence in the profession could be harmed. Mr Stevens therefore submitted that the matters of non-cooperation fit the criteria for misconduct.

50. Mr Stevens then made submissions on the issue of current impairment. He referred to the relevant case law, and submitted that impairment can be considered in relation to both public protection and the public interest.

51. Mr Stevens submitted that impairment could be found on both routes in this matter. In respect of public protection, Mr Stevens submitted that there was a real risk of repetition. He submitted that Mr Gamba had presented no evidence of remediation, no evidence of corrective steps by way of CPD or written reflections that included his understanding of the matters, no evidence of any insight, and he had continued not to engage with the GDC. Mr Stevens submitted that the matters at charge B, the clinical failings, are capable of remedy however Mr Gamba had not presented any evidence of such. He submitted that, for example, Mr Gamba had provided no tailored CPD nor written reflections on how he would act differently in the future. Mr Stevens further submitted that Mr Gamba had shown a wilful disregard to the GDC processes. He submitted that in relation to charges C, D, and E, there was little confidence that Mr Gamba would continue to show the same level of disregard to his regulator given the absence of an apology and a lack of insight. Mr Stevens therefore submitted that there was a public protection risk and that a finding of impairment should be made.

52. In respect of public interest, Mr Stevens submitted that a finding of impairment was necessary due to Mr Gamba's failing of many of the GDC Standards including 1.1, 4.1, 7.1, 1.3.2, and 9.4. He submitted that such conduct fundamentally undermines public confidence in the profession and has the potential to bring the profession into disrepute.

53. Mr Stevens lastly addressed the Committee on the matter of sanction. He submitted that the Committee must consider proportionality and consider the range of sanctions available to it. He reminded the Committee that the purpose of a sanction is not to punish, but to protect. Mr Stevens submitted that the only mitigating factor for the Committee to consider is that there is evidence of Mr Gamba's previous good character in that he has no previous ftp history. Mr Stevens however submitted that there were several aggravating factors to be considered. These were that there was a risk of harm to a large number of patients, 15 in total as charged. He also submitted that the conduct was repeated over time in relation to all 3 categories of charges; clinical failings to 15 patients over several years; he breached his suspension order for several days; and he failed to cooperate and engage on several occasions. Mr Stevens

submitted that Mr Gamba had shown a blatant and wilful disregard to the role of the regulator in his conduct. He also submitted that there was a concerning lack of insight into his conduct.

54. Mr Stevens submitted that the only appropriate sanction in this case would be that of erasure. This was in light of such serious findings and a continued lack of insight into any of the matters. Mr Stevens also submitted that Mr Gamba had breached an interim order of suspension which was a serious breach. Mr Stevens submitted that the findings in relation to Mr Gamba's conduct indicated a serious departure from the relevant professional standards. He submitted that a lesser sanction would be insufficient to meet the public interest.

Committee's Decision

55. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are 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, *'Fitness to Practise: Guidance for the practice committees' (6 January 2026)* (the GDC's Guidance) and the relevant case law. The Committee also received advice from the Legal Adviser which it accepted.

Misconduct and Deficient Professional Performance

56. The Committee first considered whether the facts found proved amounted to misconduct. In doing so, the Committee had regard to the GDC's publication, *Standards for the dental team* (September 2013).

57. The Committee considered the matters in the 3 categories as set out by Mr Stevens, these being clinical failings, practising whilst suspended, and non-cooperation with the GDC.

58. The Committee first considered the clinical failings. The Committee considered Mr Kramer's expert report that it had relied upon throughout its findings on fact, in which he had opined that Mr Gamba's standard of care fell far below the standard expected. It accepted this report. The Committee noted that there were wide-ranging failures of basic fundamental aspects of dentistry that were repeated over a prolonged period of time. The Committee determined that the failings reached the threshold for misconduct. There were serious record keeping failures for example by not updating medical histories which could pose a serious risk to a patient whilst receiving treatment. Also, there were serious clinical practise failings by prescribing antibiotics without justification that can lead to antibiotic resistance, and failings in respect of dental radiography, namely not taking X-rays or the recording of radiographs appropriately. It noted that actual harm was caused to patient 6 in that they received an inappropriate filling.

59. It determined that Mr Gamba had breached the following standards:

- Standard 4.1 - *'You must make and keep contemporaneous, complete and accurate patient records'*
- Standard 6.5 - *'You must communicate clearly and effectively with other team members and colleagues in the interests of patients'*
- Standard 7.1- '*You must provide good quality care based on current evidence and authoritative guidance'*
- Standard 9.2- '*You must protect patients and colleagues from risks posed by your health, conduct or performance'*

60. Accordingly, the Committee determined that the clinical failings amounted to misconduct.

61. The Committee next considered the non-adherence to the interim order of suspension on Mr Gamba's registration. The Committee regards the imposition of a suspension order to be an important tool for the protection of the public. In failing to adhere, there were wide-reaching ramifications in relation to patient safety and the risk to patients, and he showed a reckless disregard to his regulator. The Committee acknowledged that the GDC did not allege that Mr Gamba was dishonest or deliberate in failing to adhere to the suspension, but it considered that Mr Gamba had previously known that he was subject to an order of conditions which was to be reviewed by the IOC who imposed the suspension, and it was his duty as a professional to remain informed about any decisions that his regulator makes about his registration. The Committee determined that failing to adhere to the suspension could be properly judged as serious misconduct. It determined that it was a serious departure from what is proper and undermined public trust in the dental profession and brought the profession into disrepute. It noted that Mr Gamba saw 93 patients over many days, which posed a significant risk of harm.

62. It determined that Mr Gamba had breached the following standards:

- Standard 9.2- '*You must protect patients and colleagues from risks posed by your health, conduct or performance'*
- Standard 9.4- '*You must co-operate with any relevant formal or informal inquiry and give full and truthful information'*

63. Accordingly, the Committee determined that non-adherence with the interim suspension amounted to misconduct.

64. The Committee lastly considered non-cooperation with the GDC. The Committee considered that there is a fundamental obligation on any dental professional to cooperate to ensure that the regulator can fully carry out its functions. Despite repeated attempts by the GDC, Mr Gamba has continued to disengage. It considered that Mr

Gamba's non-cooperation with the GDC frustrated their investigation, and has left some matters, such as indemnity matters, unresolved to this day. In hindering the GDC's investigation, the Committee considered that Mr Gamba posed a risk to patient safety. It therefore determined that the facts proved amounted to misconduct.

65. It determined that Mr Gamba had breached the following standard:
    - Standard 9.4- *'You must co-operate with any relevant formal or informal inquiry and give full and truthful information'*

66. Accordingly, the Committee determined that the non-cooperation with the GDC amounted to misconduct.

67. The Committee considered that Mr Gamba had breached fundamental standards of dentistry, with the clinical failings relating to 15 patients over a considerable period of time, posing a serious risk to patients safety. Mr Gamba breached an interim order of suspension which was put in place to protect the public, and showed a reckless disregard to his regulator. Mr Gamba failed to cooperate with the GDC which is an essential requirement for any registrant. As a result, the Committee determined that the proved facts in relation to each of the 3 strands amounted separately to misconduct.

68. In light of the Committee's finding of misconduct in relation to the facts found proved at charge B, the alternative of DPP falls away.

Impairment

69. The Committee then considered whether Mr Gamba's fitness to practise is currently impaired by reason of his misconduct on the grounds of the protection of the public and/or is in the wider public interest.

70. The Committee firstly considered the route of public protection to a finding of impairment. The Committee considered risk of harm to patients and determined that his clinical failings had posed a significant risk to 15 patients over a significant period of time. The Committee also in determining that a risk to patients was present in Mr Gamba's practise considered that the risk was exacerbated by his treating of 93 patients over 8 days whilst he was suspended and should not have been practising. The Committee considered whether this risk has been remediated and whether there remains a risk to patients. The Committee concluded that that whilst the clinical failings are remediable, there is no evidence before it that Mr Gamba has remedied his clinical practise or gained any insight into his conduct. The Committee determined that given the lack of any evidence that Mr Gamba has changed his practise, it could not be confident that the conduct would not be repeated. The Committee considered that providing safe, good quality, evidence based care to patients is a fundamental tenet of the profession, and that Mr Gamba had breached this in his conduct. The Committee therefore determined that Mr Gamba is currently impaired by reason of his misconduct.

71. The Committee next considered whether a finding of impairment was required within the public interest. The Committee considered that there was a serious failing on Mr Gamba's part to provide a good standard of care to several patients for a significant duration, there was a serious breach of an interim order by his practising whilst suspended, he breached standards by not engaging with his regulator, and he had not acknowledged any of his wrongdoing. The Committee considered that an informed member of the public would be shocked and troubled if no finding of impairment was made in light of such serious findings. It considered that public confidence in the dental profession would also be undermined if a finding of impairment were not made. The Committee considered that fellow professionals would find Mr Gamba's conduct to be deplorable, and that a finding of impairment was required as not doing so had the potential to bring the profession into disrepute. It therefore determined that Mr Gamba is impaired on public interest grounds.

72. Accordingly, the Committee has determined that Mr Gamba's fitness to practise is currently impaired by reason of his misconduct on both the routes of the protection of the public and the public interest.

Sanction

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

74. The Committee considered the mitigating and aggravating factors in this case and took into consideration the relevant paragraphs in the *GDC's Guidance* on these matters.

75. The Committee considered that the only mitigating factor in this case was that Mr Gamba has no previous fitness to practise history.

- The Committee however considered there to be numerous aggravating factors. These were that: There was a serious risk of harm to the patients who were treated by Mr Gamba, and actual harm caused to patient 6 by way of an inappropriate filling.
- The misconduct was sustained and repeated over a period of time in that there were clinical failures, of a similar nature, in Mr Gamba's treatment of the 15 patients over a significant period of time. The Committee also considered that Mr Gamba's breach of his interim suspension was not an isolated incident, but a breach that took place over several days, in which he saw 93 patients.
- There was a blatant disregard of the role of the GDC and the systems regulating the professions. This was in that Mr Gamba did not adhere to the interim order

of suspension imposed on his registration for a period of 8 days, and in this time he saw 93 patients. He also did not cooperate with the GDC's investigation.

- There is a lack of insight on Mr Gamba's part, in that there is no evidence of any remediation or reflections on his conduct.

77. The Committee decided that it would be inappropriate to conclude this case with no further action. It would not satisfy the public interest given the serious nature of the findings made at this hearing.

78. The Committee considered a sanction of a reprimand; however it determined that this would also be insufficient to address the serious findings.

79. The Committee next considered a sanction of conditions. The Committee reminded itself that conditions were only suitable when it could be confident that a registrant may comply. The Committee considered that Mr Gamba had previously continued to practise whilst under an interim suspension, for several days. It also considered that Mr Gamba has not been engaging with the GDC. It therefore concluded that it could not be confident that Mr Gamba would comply with any conditions if imposed. The Committee also determined that no workable conditions could be formulated to address the matter of non-engagement with the GDC. In any event, the Committee determined that a sanction of conditions was not sufficient given the seriousness of the findings made at this hearing.

80. The Committee next considered whether to impose a sanction of suspension. The Committee however determined that in light of such serious findings, a suspension did not reflect the seriousness of the case and would not be sufficient in the public interest. It considered that Mr Gamba had previously failed to adhere to an interim order of suspension. The Committee considered this may be evidence of an attitudinal problem, that was further enhanced by Mr Gamba's continued non-cooperation with the GDC.

81. The Committee therefore turned to a sanction of erasure. It referred to the Guidance, which sets out a non-exhaustive list of criteria for when an erasure may be the appropriate order, and was satisfied that Mr Gamba's conduct reflected many of these aspects. It considered Mr Gamba's conduct to be a serious departure from the relevant professional standards. It also concluded that there was a continuing risk of serious harm to patients in that the clinical failings were serious and numerous, there is a real risk of repetition, and Mr Gamba continued to treat patients whilst suspended. The Committee noted there is a persistent lack of insight by Mr Gamba into the seriousness of his actions, in that he has disengaged entirely and not provided any form of evidence of insight. The Committee lastly determined that any lesser sanction would be insufficient to meet the public interest given the serious failings.

82. In all the circumstances, the Committee determined that the only appropriate and proportionate sanction in this case is one of erasure. In imposing this highest sanction, the Committee was satisfied that the need to protect the public and the wider public interest outweighed Mr Gamba's own interests.

83. The interim order of suspension currently in place on Mr Gamba's registration is hereby revoked, given the sanction imposed at this hearing.

84. Unless Mr Gamba exercises his right of appeal, his name will be erased from the Dental Register, 28 days from the date that notice of this Committee's determination is deemed to have been served upon him.

85. The Committee next invited submissions from Mr Stevens, as to whether an immediate order of suspension should be imposed on Mr Gamba's registration to cover the 28-day appeal period, pending the taking effect of its substantive direction for erasure.

Decision on an immediate order

86. The final stage at this hearing was to consider whether an immediate order should be placed upon Mr Gamba's registration, under rule 22 of the Rules.

87. Mr Stevens made an application for an immediate suspension order to be imposed on Mr Gamba's registration under Section 30(1) of the Dentists Act 1984. He submitted that the Interim Order of suspension has been revoked at this hearing and therefore in the absence of any immediate action, Mr Gamba would theoretically be free to practise with no restriction for at least 28 days. If he were to appeal, this period could be longer. Mr Stevens submitted that an immediate order for suspension is necessary for the protection of the public and is otherwise in the public interest, following the serious findings made and the current risks that have been clearly identified in the Committee's determination.

88. The Committee accepted the advice of the Legal Adviser, who drew its attention to the relevant guidance contained in the GDC's Fitness to Practise: Guidance for the practice committees (January 2026).

89. The Committee determined that the imposition of an immediate order of suspension on Mr Gamba's registration is necessary for the protection of the public and is in the public interest. It considered its findings that Mr Gamba's misconduct was of a serious nature, and posed a risk to patients and the public interest. The Committee referred to its reasons given in its substantive decision.

90. The effect of this immediate order is that Mr Gamba's registration is now suspended. Unless Mr Gamba exercises his right of appeal, the substantive suspension will replace the immediate suspension upon the expiry of the 28-day appeal period. Should he exercise his right of appeal, this immediate order shall remain in force pending the resolution of the appeal.

91. That concludes this determination.

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