PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

12 to 30 May 2025
(non-sitting days: 12 and 16 May 2025)

Name:	LORD, Siavash Toofani
Registration number:	265237
Case number:	CAS-196652

General Dental Council:	Rebecca Vanstone, Counsel Instructed by Clare Hastie, Kingsley Napley LLP
Registrant:	Present Represented by Scott Ivill, Counsel Instructed by Sadie O'Reilly, Weightmans LLP

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension
Duration:	Six Months
Immediate order:	No immediate order

Committee members:	Anne Ng	(Chair, Dental Care Professional Member)
	Gillian Jones	(Dentist Member)
	Paul Hepworth	(Lay Member)
Legal Adviser:	Alice Moller	
Committee Secretary:	Lola Bird	

LORD, Siavash Toofani, a dentist, BDS University of Sheffield 2016 is summoned to appear before the Professional Conduct Committee on 12 May 2025 for an inquiry into the following charge:

The charge (as amended):

"The Council alleges that you, Siavash Lord, a registered dentist:

1. *At all material times you were working for Company A at Practice 1 ('the Practice') and provided treatment to the patients listed within the allegations.*
2. *Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for **Patient A** in that you did not:*
    a. *Carry out, adequately or at all, a Basic Periodontal Examination ("BPE");*
    b. *Complete, adequately or at all, dental charting on 21 February 2020;*
    c. *Undertake, adequately or at all, a dental history on 21 February 2020;*
    d. *Assess, adequately or at all, the cause of incisal tooth wear on 21 February 2020;*
    e. *Take appropriate radiographs prior to fitting whitening trays on 10 March 2020;*
    f. *Discuss adequately or at all, the risks and benefits of composite bonding to the patient's upper and / or lower teeth prior to 21 July 2020;*
3. *As a result of your conduct at 2(a) and / or 2(d) and / or 2(e) and / or 2(f), you did not obtain the patient's valid consent for treatment.*
4. *Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of record keeping for **Patient A** in that you did not record, adequately or at all:*
    a. *A BPE;*
    b. *Dental charting;*
    c. *Dental history;*
    d. *The cause of incisal tooth wear on 21 February 2020;*
5. *On or around 17 September 2020, you failed to maintain an adequate standard of record keeping for **Patient B** in that you did not:*
    a. *Record, adequately or at all, a BPE;*
    b. *Record, adequately or at all, dental charting;*
    c. *Amend templated notes.*
6. *On 20 July 2020 you failed to maintain an adequate standard of care for **Patient C** in that you:*
    a. *Did not carry out adequately or at all, a BPE;*

b. *Did not complete, adequately or at all, dental charting*

c. *Took an Orthopantomogram on 20 July 2020 which was of insufficient diagnostic quality.*

7. *On or around 20 July 2020 you failed to maintain an adequate standard of record keeping for **Patient C** in that you did not record any or any adequate details of the patient's appointment.*

8. *Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:*

    a. *Carry out, adequately or at all, a BPE on 05 March 2020;*

    b. *Complete, adequately or at all, dental charting on 05 March 2020;*

    c. *Undertake, adequately or at all, a dental history on 05 March 2020;*

    d. *Take appropriate radiographs prior to undertaking tooth whitening on 02 July 2020;*

    e. *Take appropriate radiographs prior to placing restorations at the UL4 and UR4 on 30 July 2020;*

9. *As a result of your conduct at 8(a) and / or 8(b) and / or 8(d) and / or 8(e) above, you did not obtain the patient's valid consent for treatment.*

10. *On or around 05 March 2020, you failed to maintain an adequate standard of record keeping for **Patient D** in that you did not record, adequately or at all:*

    a. *A BPE;*

    b. *Dental charting;*

    c. *Dental history.*

11. *On 26 June 2020, you failed to provide an adequate standard of care to **Patient E** in that you did not diagnose and / or treat caries at the UR7 and / or LR6 and / or LL6.*

12. *Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:*

    a. *Did not carry out, adequately or at all, a BPE;*

    b. *Did not complete, adequately or at all, dental charting;*

    c. *Did not undertake, adequately or at all, a dental history;*

    d. *Did not take any, or any adequate, bitewing radiographs;*

    e. *Took an OPG on 20 July 2020 which was of insufficient diagnostic quality;*

    f. *Did not treat or plan to treat, active periodontal disease present;*

13. *Your conduct at 12(a) and / or (f) above, exposed the patient at an increased risk of harm.*

14. *Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of record keeping for **Patient F** in that you did not record, adequately or at all:*
    a. *A BPE;*
    b. *Dental charting;*
    c. *Dental history.*
15. *Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of care for **Patient G** in that you did not:*
    a. *Carry out, adequately or at all, a BPE;*
    b. *Complete, adequately or at all, dental charting;*
    c. *Carry out a detailed / adequate orthodontic assessment.*
16. *Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of record keeping for **Patient G** in that you did not:*
    a. *Record, adequately or at all, a BPE;*
    b. *Record, adequately or at all, dental charting;*
    c. *Record, adequately or at all, dental history;*
    d. *Amend templated notes.*
17. *Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for **Patient H** in that you did not:*
    a. *Carry out, adequately or at all, a BPE on 13 or 18 March 2020;*
    b. *Complete, adequately or at all, dental charting on 13 or 18 March 2020;*
    c. *Take appropriate radiographs prior to undertaking tooth whitening on 01 July 2020;*
    d. *Report, adequately or at all, on the radiograph taken on 29 July 2020.*
18. *As a result of your conduct at 17(a) and / or 17(c) above, you did not obtain the patient's valid consent for treatment.*
19. *On or around 13 March 2020, you failed to maintain an adequate standard of record keeping for **Patient H** in that you did not record adequately or at all:*
    a. *A BPE;*
    b. *Dental charting.*
20. *Between 19 July 2020 and 16 January 2021 you failed to maintain an adequate standard of care for **Patient I** in that you did not:*
    a. *Carry out, adequately or at all, a BPE;*

b. *Complete, adequately or at all, dental charting.*

21. *Between 19 July 2020 and 16 January 2021, you failed to maintain an adequate standard of record keeping for **Patient I,** in that you did not record, adequately or at all:*

    a. *A BPE;*

    b. *Dental charting.*

22. *Between 15 January 2020 and 09 December 2020 you failed to maintain an adequate standard of care for **Patient J** in that you did not:*

    a. *Carry out, adequately or at all, a BPE;*

    b. *Complete, adequately or at all, dental charting.*

23. *Between 15 January 2020 and 09 December 2020, you failed to maintain an adequate standard of record keeping for **Patient J** in that you did not record, adequately or at all:*

    a. *A BPE;*

    b. *Dental charting.*

24. *Between 18 June 2020 to 08 January 2021, you failed to provide an adequate standard of care to **Patient K**, in that you:*

    a. *Did not complete, adequately or at all, dental charting on 19 June 2020;*

    b. *Took an OPG on 19 June 2020 which was of insufficient diagnostic quality;*

    c. *Did not diagnose and / or treat caries at the UR7 and / or UR8.*

25. *On or around 19 June 2020, you failed to maintain an adequate standard of record keeping for **Patient K** in that you did not record, adequately or at all, dental charting.*

26. *On or around 18 June 2020, you failed to maintain an adequate standard of record keeping for **Patient L** in that you did not record, adequately or at all, details of the appointment.*

27. *Between 19 July 2020 and 18 December 2020, you failed to provide an adequate standard of care to **Patient M**, in that you did not:*

    a. *Carry out, adequately or at all, a BPE on 20 July 2020;*

    b. *Complete, adequately or at all, dental charting on 20 July 2020;*

    c. *Diagnose and / or treat caries at the LL7.*

28. *On or around 20 July 2020, you failed to maintain an adequate standard of record keeping for **Patient M** in that you did not record, adequately or at all:*

    a. *A BPE;*

    b. *Dental charting.*

Other matters

29. *WITHDRAWN:*
    a. *WITHDRAWN;*
    b. *WITHDRAWN;*
    c. *WITHDRAWN.*
30. *On or before 22 February 2021 and at the time of the Covid-19 pandemic you failed to:*
    a. *Maintain adequate standards of cross infection control;*
    b. *Adhere to rules of social distancing;*
    c. *Ensure you were using Personal Protective Equipment ("PPE") correctly .*
31. *As a result of your conduct at 30(a) and / or (b) and / or (c) above, you put patient safety at risk.*
32. *Between 01 July 2020 and 31 January 2021, you misappropriated monies from Company A by causing and / or allowing:*
    a. *Patients to pay money into your bank account; and / or*
    b. *Patients to make payment through a finance company which was then paid into your bank account.*
33. *Your conduct at 32 above was:*
    a. *Misleading, in that you were not entitled to receive monies from patients;*
    b. *Dishonest, in that you knew the monies should have been paid directly to Company A.*
34. *On or around 03 February 2021 you told Company A that the diversion of patient funds to your bank account was directly linked to the suspension of patient finance.*
35. *The information provided to Company A as detailed at 34 above was incorrect.*
36. *Your conduct at 34 above was:*
    a. *Misleading, as it suggested that funds had not been diverted until patient finance had been suspended;*
    b. *Dishonest, as you knew the diversion of patient funds had begun before any patient finance had been suspended.*
37. *For a period up until 03 February 2021 you stated on your social media page that you were a 'Dental Practice Owner'.*
38. *Your conduct at 37 above was:*
    a. *Misleading, as it suggested you owned a dental practice, when you did not;*

b. *Dishonest, as it was intended to convey that you owned a dental practice, when you did not.*

And by reason of the matters identified above, your fitness to practise is impaired by reason of your misconduct and / or deficient professional performance."

Mr Lord,

1. This is a Professional Conduct Committee hearing in respect of a case brought against you by the General Dental Council (GDC). The factual allegations set out in the charge concern the standard of care you provided to 13 patients (Patients A to M), as well as a number of other matters, including allegations of dishonesty.

2. You are represented at these proceedings by Mr Scott Ivill, Counsel. The Case Presenter for the GDC is Ms Rebecca Vanstone, Counsel.

3. The hearing was scheduled to begin on 12 May 2025, but that first day was designated as a day for the Committee to read the case papers. Whilst the Committee and parties convened briefly on 13 May 2025 to discuss the case timetable, the hearing did not formally commence until 14 May 2025.

4. The hearing is being conducted in a hybrid format, with the Committee and parties having attended in person at the Dental Professionals Hearings Service to hear the factual evidence. The hearing has continued remotely from 22 May 2025, with everyone now participating by Microsoft Teams video-link.

Decision on preliminary application to amend the charge – 14 May 2025

5. At the outset of the hearing, Ms Vanstone made an application to amend the charge, pursuant to Rule 18 of the *GDC (Fitness to Practise) Rules 2006 Order of Council*. She first applied to amend the date in head of charge 11 from '*20 June 2020*' to '*26 June 2020*'. She submitted that based on the evidence, 26 June 2020 was the relevant date of the appointment.

6. Ms Vanstone also applied to withdraw the allegation at head of charge 29(a), which related to the storage of patient records. She submitted that in light of information disclosed as part of your defence case, the GDC had taken the view that head of charge 29(a) was no longer capable of being proved.

7. Mr Ivill confirmed that he did not oppose either of the amendments proposed by the GDC.

8. In addition to her application, following a question raised by the Committee, Ms Vanstone confirmed that, in keeping with the usual practice of the GDC, she wished to maintain the anonymity

of 'Company A' throughout the charge. She therefore agreed that where the company's name inadvertently appeared in the charge it should be anonymised to read 'Company A'.

9. Having heard from both parties, and having accepted the advice of the Legal Adviser, the Committee acceded to the GDC's application to amend the charge. It was also content that the name of the company inadvertently referred to in the original charge should appear throughout as 'Company A'. In reaching its decisions, the Committee took into account that no objection was raised on your behalf. It was satisfied, having had regard to the merits of the case and the fairness of the proceedings, that no injustice would be caused by allowing the amendments, including the withdrawal of head of charge 29(a). The Committee was satisfied that withdrawing 29(a) would not amount to an under prosecution of the case by the GDC.

10. The charge was amended accordingly.

Admissions to the amended charge – 14 May 2025

11. The Committee next heard your admissions to the amended charge. Mr Ivill told the Committee that you admitted the following heads of charge: 1, 4(a), 4(b), 4(c), 4(d), 5(a), 5(b), 5(c), 6(c), 7, 10(a), 10(b), 10(c), 12(d), 12(e), 12(f), 13 in relation to 12(f), 14(a), 14(b), 14(c), 16(a), 16(b), 16(c), 16(d), 17(c), 17(d), 18 in so far as it relates to 17(c), 19(a), 19(b), 21(a), 21(b), 23(a), 23(b), 24(b), 24(c), 25, 26, 27(c), 28(a), 28(b), 30(a), 30(b), 30(c), 31, 37 and 38(a).

Decision on admissions to the amended charge – 14 May 2025

12. The Committee had regard to the *'Guidance on admissions made at the preliminary stage of fitness to practise hearings'* issued by the Dental Professionals Hearings Service in October 2022. It accepted the advice of the Legal Adviser.

13. The Committee took into account that you are legally represented at this hearing, and it noted Mr Ivill's confirmation that in making your admissions you understood that where it is alleged that you *'failed'* to do something, this means that there was a breach of duty on your part. Having received that confirmation, the Committee was satisfied that your admissions were unambiguous, and it was content to accept them.

14. Accordingly, all the heads of charge that you admitted were announced as 'Admitted and found proved'.

Decisions on further applications to amend the charge – 15 and 19 May 2025

15. During the course of the hearing, the Committee acceded to two further applications to amend the charge made by Ms Vanstone. The first of these applications was granted on 15 May 2025, when Ms Vanstone applied to withdraw the remainder of head of charge 29, so that head of charge 29 would be withdrawn in its entirety. She informed the Committee that the application was being made as a result of further discussions between the parties. Mr Ivill supported the application.

16. The next application was granted by the Committee on 19 May 2025, when Ms Vanstone applied to add the date '*18 March 2020'* to heads of charge 17(a) and 17(b), so that those allegations would read:

> **17**. *Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for Patient H in that you did not:*
>
> ***(a)*** *Carry out, adequately or at all, a BPE on 13 or 18 March 2020*
>
> ***(b)*** *Complete, adequately or at all, dental charting on 13 or 18 March 2020*

17. Ms Vanstone told the Committee that Mr Balraj Dhami, the GDC's expert witness in this case, believed that the relevant appointment may have been on 18 March 2020, but accepted that it could have been 13 March 2020. In the circumstances, Ms Vanstone requested that both dates appear in heads of charge 17(a) and 17(b). Mr Ivill did not object to this application.

18. In acceding to the respective applications made on 15 and 19 May 2025, the Committee accepted the advice of the Legal Adviser. It was satisfied that the amendments could be made without causing injustice. The charge was amended accordingly.

Background and summary of the GDC's opening submissions

19. At all material times you were an Associate Dentist working for Company A at Practice 1. The matters in this case arose from a referral made to the GDC on 19 February 2021 by Company A, in which concerns were raised about your clinical practice, record keeping, advertising and concerns that you had received payments for treatment directly from patients.

20. Following the GDC's investigation into the matters, it brought the charges at this hearing which relates to your treatment of Patients A to M between February 2020 and January 2021, as well as additional allegations, including your alleged misappropriation of monies from Company A. There are also allegations relating to you having referred to yourself on your social media page as a 'Dental Practice Owner' for a period of time.

21. The evidence obtained by the GDC includes an expert report prepared by Mr Dhami, who considered the clinical records of the 13 patients in this case. In her opening submissions for the GDC, Ms Vanstone told the Committee that Mr Dhami's expert opinion forms the basis of the clinical allegations relating to Patients A to M, as set out at heads of charge 2 to 28. In summary, it is alleged that you failed to maintain an adequate standard of care for a number of the patients. There are also alleged failures in record keeping. You admitted a number of the clinical allegations at the preliminary stage of the hearing.

22. The other matters in this case are set out from heads of charge 30 to 38, some of which you also admitted. In her opening, Ms Vanstone addressed the Committee on the matters that remained in dispute. These were the non-clinical allegations relating to your alleged misappropriation of monies from Company A, and a matter relating to your social media page. In outlining the evidence relied upon by the GDC in relation to these non-clinical matters, Ms Vanstone drew the Committee's

attention to the witness statements provided by Witness 1, the Regional Clinical Director at Company A and an Associate Dental Practitioner, and Witness 2, who was, at the material time, the Operational Audit Manager and Financial Crime Network Officer. Ms Vanstone explained that Witness 1 and Witness 2 had conducted investigations into the concerns on behalf of Company A.

23. Ms Vanstone highlighted Witness 1's written evidence regarding his completion of an audit record sheet in respect of 17 patients. She outlined that Witness 1 had exhibited with his witness statement, a clinical record summary, which he said showed the discrepancies in payment between the cost of the patients' treatment and how much had been recorded on the internal computer system, Software of Excellence (SOE), as having been paid to Practice 1 by the patients. Witness 1 also exhibited with his witness statement notes of meetings held on 28 January 2021, 3 February 2021 and 4 February 2021, including about the identified financial irregularities and your social media account.

24. The Committee's attention was also drawn to the exhibits provided by Witness 2, which include a list of patients who were said to have paid you directly for their treatment via bank transfer, or through a named finance company. That finance company will be referred to as 'Finance Company T' for the purposes of this determination. Witness 2 also exhibited information relating to money you paid back to Company A from 26 January 2021 to 10 February 2021. Ms Vanstone noted that Witness 2 also provided evidence in her witness statement in relation to the financial arrangements that were in place at Practice 1 for patients to pay for their treatment. Ms Vanstone highlighted Witness 2's written evidence that it was not usual for patients to make payments directly to clinicians. Further, that Finance Company T was not used by Company A. Witness 2's evidence is that Company A used another named finance provider, referred to in this determination as 'Finance Company H'.

25. In summarising the GDC's case against you in relation to the financial matters, Ms Vanstone referred to your written evidence that the money paid directly to you by patients, or through Finance Company T, was done for the patients' ease and convenience. Also, that you only held the money in your business bank account on a temporary basis before you transferred the entirety of the funds to Company A. However, Ms Vanstone submitted that it was the GDC's position that the bypassing of the approved financial systems in place at Practice 1, and the taking of payments directly from patients, was misleading. She further submitted that for a period of time, a significant amount of money was diverted from Practice 1's funds. It was Ms Vanstone's submission that such conduct would be regarded as dishonest by the standards of ordinary decent people.

26. In relation to the allegations concerning your social media page, you admitted at the preliminary stage that referring to yourself as a 'Dental Practice Owner' over the period in question was misleading. It was noted that you did not own a dental practice at the time. Ms Vanstone contended that your conduct in that regard was also dishonest, which you denied. She submitted that referring to yourself as a 'Dental Practice Owner', could have caused members of the public to believe that you owned the business at which you were working during the material time, which you did not.

Evidence

27. As outlined, the documentary evidence received by the Committee from the GDC included the following:

- The expert report of Mr Balraj Dhami dated 16 December 2024
- The witness statement of Witness 1 dated 28 November 2024 along with associated exhibits.
- The witness statement of Witness 2 dated 4 December 2024, along with associated exhibits.

28. The Committee was also provided with a supplementary witness statement from Witness 1 dated 14 May 2025, as well as witness statements from three further patients dated 18 November 2024, 3 December 2024 and 21 December 2024. All of these patients refer to the payment plan that was on offer to them through Finance Company T.

29. Also before the Committee were copies of the clinical records for the 13 patients in this case and your written Associate Agreement with Practice 1, which was obtained by the GDC following further enquiries made during this hearing at the request of the Committee.

30. In addition, the Committee heard oral evidence from Witness 1, Witness 2 and Mr Dhami, who all appeared remotely by Microsoft Teams video-link.

31. The Committee did have the opportunity to hear from the three patient witnesses who have provided witness statements, but it decided that it had no questions to ask of them that would assist beyond their written evidence.

32. The evidence received in relation to your defence case was your witness statement prepared for this hearing, dated 8 May 2025, a Memorandum of Sale dated 30 July 2020 in relation to a dental practice that you subsequently purchased, and a number of character references tendered on your behalf.

33. Additionally, the Committee was provided with an expert report dated 11 May 2025, prepared by Mr Don McGrath, the expert witness instructed on your behalf.

34. A joint expert report dated 14 May 2025, from Mr Dhami and Mr McGrath was also before the Committee.

35. The Committee heard oral evidence from you, which you gave in person. It also heard oral evidence from Mr McGrath, who appeared remotely by Microsoft Teams video-ink.

FINDINGS OF FACT – 27 May 2025

36. The Committee considered all the evidence presented to it, both documentary and oral. It took account of the closing submissions made by Ms Vanstone and Mr Ivill in relation to the alleged facts.

37. The Committee accepted the advice of the Legal Adviser in relation to the burden and standard of proof, the quality of evidence (*Byrne v GMC* [2021] EWHC 2237), how to approach the evidence seen and heard, including that the Committee should draw its own conclusions, and the relevance of good character. The Committee also heard and accepted the Legal Adviser's advice in relation to the correct test for dishonesty, as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67.

38. The Committee considered each of the outstanding allegations separately, bearing in mind that the burden of proof rests with the GDC, and that the standard of proof is the civil standard, that is, whether the alleged matters are proved on the balance of probabilities.

39. The Committee's findings are set out in the table below. For completeness, these include those matters that were announced as 'Admitted and found proved' at the preliminary stage of the hearing.

1	*At all material times you were working for Company A at Practice 1 ('the Practice') and provided treatment to the patients listed within the allegations.* **Admitted and found proved.**
Patient A	
2(a)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for **Patient A** in that you did not:* *Carry out, adequately or at all, a Basic Periodontal Examination ("BPE");* **Found not proved.** The Committee considered the clinical records for Patient A. It noted that in relation to an appointment on 21 February 2020 there is reference in the records to a BPE having been carried out. However, the BPE scores themselves are not included. The Committee took into account the joint expert opinion that the recording of BPE scores is a necessary component of the examination. The GDC maintained that the absence of BPE scores from your clinical records for Patient A over the period in question indicates that you did not carry out a BPE adequately, or at all. You stated in your witness statement that "*My standard clinical practice in such consultations before commencing any treatment, both at this time and currently, entails thorough undertaking of BPEs and dental charting. I would have carried out a BPE and dental charting on 21 February 2020. I note that my records entry of 21 February 2020 notes "BPE taken" and "charting done" although I accept the BPE examination and charting are not present in the records. This may have been a record keeping deficiency on my part where these details were not recorded, despite being carried out or may be due to IT software issues within the practice at the time."*

	The Committee found your oral evidence to be consistent with your written evidence. You told the Committee that the absence of BPE scores from your clinical records for Patient A, and from your clinical records for a number of the other patients in this case, was due to failings in record keeping, and not because you did not carry out BPEs for the patients. Whilst you admitted that there may have been record keeping omissions on your part in some of the instances, you also explained that there were ongoing IT issues at Practice 1, which affected the keeping of accurate records. You stated that BPE scores and dental charting were usually entered into separate tabs within a patient's computer records, as opposed to being recorded within the main body of the clinical notes. It was your evidence that the BPE scores and dental charting recorded in those separate tabs were regularly lost due to IT software issues which affected the saving of information. You told the Committee that you would often go back into patients' clinical records to check if all recorded information had been saved, and if not, you would re-input the missing details. You stated that the IT issues at Practice 1 existed almost throughout the 10-month period concerned in this case, and that you repeatedly reported the problems to practice management staff. In considering your evidence, the Committee remained mindful that the burden of proof at these proceedings rests with the GDC. The Committee had regard to the supplementary witness statement of Witness 1, relied upon by the Council, in which Witness 1 stated, *"I have been asked whether I was aware of any IT issues at the Practice at the relevant time, namely in 2020 and 2021. IT issues meaning any difficulties with the saving of radiographs or other clinical information not being saved onto Software of Excellence (SOE). I can confirm that I was not aware of any IT issues during this time period".* However, the Committee also took into account Witness 1's oral evidence that he had not visited or worked at Practice 1 during the material time. The Committee noted that the GDC did not adduce any evidence from members of staff who had worked at Practice 1 over the relevant timeframe. There is no evidence from any members of staff who had direct working experience of the computer system at Practice 1, or who worked alongside you to observe your usual clinical and record keeping practices. In the absence of such evidence, the Committee concluded that it could not discount that the omission of BPE scores from your clinical records for Patient A was due to a record keeping failing, caused by your own omission, or by IT software issues, or a combination of both, in that you did not go back and check that all the records for Patient A had been successfully saved onto the system. In all the circumstances, the Committee was not satisfied that the GDC proved on the balance of probabilities that you did not carry out, adequately or at all, a BPE for Patient A. In reaching its conclusion, the Committee took into account that both expert witnesses accepted that the absence of a clinical record did not necessarily mean that the activity was not carried out.
2(b)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for **Patient A** in that you did not:* *Complete, adequately or at all, dental charting on 21 February 2020;*

	Found not proved. The Committee found this allegation at head of charge 2b not proved for the same reasons given in respect of head of charge 2a above. It took into account that it is the same factual evidence that applies to the issue of dental charting. The Committee noted from the clinical records for Patient A on 21 February 2020 that it is recorded *"charting done"*. However, no dental charting appears in the records. The Committee noted the joint expert opinion that dental charting should have been undertaken as part of the examination of the patient. The GDC maintained that the absence of dental charting from your records for Patient A on 21 February 2020 indicates that you did not complete dental charting adequately, or at all. Your evidence was that it was your standard practice to complete dental charting at such appointments, and that you would have completed dental charting for Patient A on 21 February 2020. You acknowledged that there is no dental charting present in the patient's clinical records, and, as noted previously, you stated in your witness statement that "*This may have been a record keeping deficiency on my part where these details were not recorded, despite being carried out or may be due to IT software issues within the practice at the time."* The Committee took into account that the GDC did not adduce any evidence from members of staff who had direct working experience of the computer system at Practice 1 over the relevant timeframe. Nor was any evidence provided by the GDC from members of staff at Practice 1 who worked alongside you to observe your usual clinical and record keeping practices. In the absence of such evidence, the Committee concluded that it could not discount that the omission of dental charting from your clinical records for Patient A on 21 February 2020 was due to a record keeping failing. In all the circumstances, the Committee was not satisfied that the GDC proved on the balance of probabilities that you did not complete dental charting for Patient A, adequately or at all.
2(c)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for* ***Patient A*** *in that you did not:* *Undertake, adequately or at all, a dental history on 21 February 2020;* **Found proved.** The Committee had regard to the clinical records for Patient A on 21 February 2020. It noted that there is no record of the patient's dental history. The joint expert opinion is that undertaking a dental history was a necessary component of the patient's examination. Your evidence was that you would have obtained a full dental history from Patient A on 21 February 2020, as part of your usual practice. However, you accepted that a dental history is not recorded. In reaching its decision on whether the absence of a record on 21 February 2020 was due to you not having undertaken a dental history for Patient A on this date, the Committee had regard to all the evidence. This included that there is no

	apparent reference in the patient's clinical records to a dental history having been obtained. The Committee took into account your evidence that unlike the BPE scores and dental charting, which were usually recorded in a separate tab, any records made regarding a patient's dental history would appear in the main body of the clinical records. Whilst you maintained in your oral evidence that the absence of a dental history from the main body of Patient A's clinical records on 21 February 2020 was due to a record keeping failure, the Committee took into account that you made comprehensive notes in relation to other clinical information. It was the finding of the Committee, having considered the evidence, that it was more likely than not that you did not undertake a dental history in respect of Patient A on 21 February 2020, and that is why that information is missing from the main body of the clinical records. In making its finding, the Committee considered the possibility that the absence of a record could have been as a result of an IT software issue, but again noted that other information within the records appears to have been successfully saved.
2(d)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for **Patient A** in that you did not:* *Assess, adequately or at all, the cause of incisal tooth wear on 21 February 2020*; **Found proved.** It is stated in the clinical records for Patient A on 21 February 2020 that *"Upper 3-3 worn edges and tooth wear…"*, with no information recorded regarding the cause of that tooth wear. It was alleged on this basis that you failed to assess adequately, or at all, the aetiology of the tooth wear prior to providing the patient treatment, which included composite bonding. In your oral evidence, you acknowledged that you had not recorded the aetiology of the incisal tooth wear, but you stated that you had discussed with Patient A that the cause was bruxism. Your evidence was that the patient's bruxism was the reason you prescribed mouth guards, also referred to in the clinical records. The Committee took into account the expert evidence of Mr Dhami that mouth guards are usually prescribed to all patients who have composite bonding undertaken, in order to safeguard the composites. The Committee noted that your clinical records for Patient A on 21 February 2020 state, *"…mouth guard to protect composites".* Having considered the clinical records and the expert opinion of Mr Dhami, the Committee was satisfied on the balance of probabilities that you did not assess adequately, or at all, the cause of the incisal tooth wear. It was the finding of the Committee that it was more likely that the mouth guards you prescribed were to protect the composite bonding and not because you had made an assessment of bruxism.
2(e)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for **Patient A** in that you did not:* *Take appropriate radiographs prior to fitting whitening trays on 10 March 2020;*

	Found proved. The Committee noted that there are no radiographs included in Patient A's clinical records in relation to the date 10 March 2020. In his expert report, Mr Dhami raised the lack of radiographs on this date as a concern. In his opinion, radiographs should have formed part of the required diagnostic assessments prior to the provision of any treatment. You stated in your witness statement that *"I acknowledge there is no OPG image within the Practice records nor have I recorded that one was exposed…the OPG machine in the Practice was connected to a computer that was linked to SOE and therefore the imagery may be saved to that computer. Alternatively, the OPG image may have been lost at the time due to a system fault which was frequent".* In his oral evidence, Mr McGrath opined that you could have diagnosed any interproximal caries in Patient A's teeth without a radiograph, either visually or by using transillumination. However, there is no reference to such assessments in the clinical records for 10 March 2020. When questioned in relation to what would have been an appropriate radiograph in the circumstances, Mr McGrath stated that whilst an OPG may show some information, it may not provide a definitive view. The Committee noted that in his expert report, Mr McGrath stated that *"I believe the patient was new to the Practice from what I can understand. As a new patient to the Practice, it is advised that at least bite-wing radiographs should be taken as part of the treatment needs assessment and caries risk analysis".* The Committee accepted the expert opinion. It understood from the expert evidence, including the evidence of Mr Dhami, that bitewing radiographs would have been the appropriate radiographs for you to have taken on 10 March 2020. The Committee was satisfied from the evidence, including your own account which related to an OPG radiograph, that bitewing radiographs were not taken on 10 March 2020. Therefore, this head of charge is proved.
2(f)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of care for* ***Patient A*** *in that you did not:* *Discuss adequately or at all, the risks and benefits of composite bonding to the patient's upper and / or lower teeth prior to 21 July 2020;* **Found proved.** The Committee noted that the wording of this allegation states *"prior to 21 July 2020".* This is because, as the Committee understood from the expert opinion, it would have been best practice for you to have adequately discussed the risks and benefits of composite bonding to Patient A's upper and/or lower teeth prior to the commencement of the treatment, which was on 21 July 2020. Whilst the Committee found that there is a detailed note in the clinical records for 21 July 2020, which appear to detail an adequate discussion with Patient A about the risks and benefits of the composite bonding, there are no such records prior this date. It was the view of the Committee, taking into account the comprehensive

	nature of the note of 21 July 2020, that had such discussions taken place previously, a similar note would have appeared earlier in the clinical notes. The Committee was satisfied on the balance of probabilities that this head of charge is proved.
3	*As a result of your conduct at 2(a) and / or 2(d) and / or 2(e) and / or 2(f), you did not obtain the patient's valid consent for treatment.* **Found proved in relation to 2(d), 2(e) and 2(f) (noting that 2(a) was found not proved).** The Committee took into account the joint expert opinion that adequate assessment on 21 February 2020 of Patient A's incisal tooth wear, the taking of appropriate radiographs prior to fitting whitening trays on 10 March 2020, and an adequate discussion of the risks and benefits of composite bonding prior to starting that treatment on 21 July 2020, were all necessary components of the treatment planning process. The Committee took into account Mr McGrath's oral evidence that in his experience, it was rare for a patient not to have some insight into treatments proposed and carried out. However, it considered that Mr McGrath's comment related more to the issue of implied consent. With regard to obtaining valid consent, which is the subject of this allegation, the Committee accepted Mr Dhami's opinion. He stated in his expert report that *"In my opinion, if an adequate examination is not undertaken, the dentist would not have sufficient information to consider, what the presenting pathology was, the possible cause of any presenting pathology, what dental treatment was appropriate, and would not be able to give individualised risks and benefits of any proposed treatment, and as such would not be in a position to gain informed consent".* The Committee considered that in order for consent to be valid it must be informed. The Committee was satisfied on the evidence that this allegation at 3 is proved in relation to 2(d), 2(e) and 2(f). It concluded that you could not have obtained valid consent for treatment from Patient A having not undertaken the necessary treatment planning components at 2(d), 2(e) and 2(f).
4(a)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of record keeping for **Patient A** in that you did not record, adequately or at all:* *A BPE;* **Admitted and found proved.**
4(b)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of record keeping for **Patient A** in that you did not record, adequately or at all:* *Dental charting;* **Admitted and found proved.**

4(c)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of record keeping for **Patient A** in that you did not record, adequately or at all:* *Dental history;* **Admitted and found proved.**
4(d)	*Between 20 February 2020 and 22 July 2020, you failed to maintain an adequate standard of record keeping for **Patient A** in that you did not record, adequately or at all:* *The cause of incisal tooth wear on 21 February 2020;* **Admitted and found proved.**
Patient B	
5(a)	*On or around 17 September 2020, you failed to maintain an adequate standard of record keeping for **Patient B** in that you did not:* *Record, adequately or at all, a BPE;* **Admitted and found proved.**
5(b)	*On or around 17 September 2020, you failed to maintain an adequate standard of record keeping for **Patient B** in that you did not:* *Record, adequately or at all, dental charting;* **Admitted and found proved.**
5(c)	*On or around 17 September 2020, you failed to maintain an adequate standard of record keeping for **Patient B** in that you did not:* *Amend templated notes.* **Admitted and found proved.**
Patient C	
6(a)	*On 20 July 2020 you failed to maintain an adequate standard of care for **Patient C** in that you:* *Did not carry out adequately or at all, a BPE;* **Found not proved.** For the same reasons set out at head of charge 2(a) above.

	The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
6(b)	*On 20 July 2020 you failed to maintain an adequate standard of care for **Patient C** in that you:* *Did not complete, adequately or at all, dental charting* **Found not proved** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
6(c)	*On 20 July 2020 you failed to maintain an adequate standard of care for **Patient C** in that you:* *Took an Orthopantomogram on 20 July 2020 which was of insufficient diagnostic quality.* **Admitted and found proved.**
7	*On or around 20 July 2020 you failed to maintain an adequate standard of record keeping for **Patient C** in that you did not record any or any adequate details of the patient's appointment.* **Admitted and found proved.**
Patient D	
8(a)	*Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:* *Carry out, adequately or at all, a BPE on 05 March 2020;* **Found not proved.** For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
8(b)	*Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:* *Complete, adequately or at all, dental charting on 05 March 2020;* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.

8(c)	*Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:* *Undertake, adequately or at all, a dental history on 05 March 2020;* **Found proved.** The Committee found this allegation proved for the same reasons given previously at head of charge 2(c). It had regarded the clinical records for Patient D on 5 March 2020 and it found no record of a dental history. The joint expert opinion is that undertaking a dental history was a necessary component of the patient's examination on this date. The Committee took into account your evidence that you would have obtained a full dental history from Patient D, in accordance with your usual practice. However, given that there are detailed notes in the records in relation to other clinical matters, including comprehensive notes on teeth whitening, the Committee concluded on the balance of probabilities that the absence of any notes in relation to dental history is because you did not take one from Patient D.
8(d)	*Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:* *Take appropriate radiographs prior to undertaking tooth whitening on 02 July 2020;* **Found proved.** The Committee noted that there is no indication in Patient D's clinical records that appropriate radiographs were taken prior to the tooth whitening treatment you provided on 2 July 2020. The Committee accepted the expert evidence that appropriate radiographs in this context would have been bitewing radiographs. In his expert report, Mr Dhami stated that "*no bitewing radiographs were exposed to check the dental status of the posterior teeth and identify any dental pathology that may need addressing before tooth whitening was undertaken and restorations were placed at UR4 and UL4".* In your evidence, you stated that you believed that the frequent IT system failures may have been responsible for the absence of any radiographs in this instance. You stated that there were often failures with radiographic images transferring to the relevant computer system, and that in some cases radiographs had to be re-taken. The Committee noted that you further stated in cross-examination that you would have made reference to any IT system failure in the clinical notes, if one had occurred. You also stated that you would have recorded in the notes if any radiographs had to be re-taken. There is no reference in the clinical notes to any IT system failures that affected the taking of appropriate radiographs of Patient D prior to the tooth whitening treatment. However, there are comprehensive notes in the clinical records on a number of other matters relating to the patient's treatment. In all the

	circumstances, the Committee was satisfied on the balance of probabilities that you failed to maintain an adequate standard of care for Patient D in this instance, as you did not take appropriate radiographs to check the dental status of the teeth and to identify any dental pathology prior to providing the tooth whitening treatment.
8(e)	*Between 04 March 2020 and 04 July 2020, you failed to maintain an adequate standard of care for **Patient D** in that you did not:* *Take appropriate radiographs prior to placing restorations at the UL4 and UR4 on 30 July 2020;* **Found proved.** For the same reasons given above at head of charge 8(d). The Committee noted Mr Dhami's opinion that bitewing radiographs should have been taken prior to placing these restorations on 30 July 2020. The Committee had regard to the absence of any clinical notes regarding IT system failures that affected the taking of appropriate radiographs of Patient D prior to the restorations. It also took into account the presence of comprehensive notes on a number of other matters relating to the patient's treatment. In all the circumstances, the Committee was satisfied on the balance of probabilities that you failed to maintain an adequate standard of care for Patient D in this instance, as you did not take appropriate radiographs to check the dental status of the teeth and identify any dental pathology prior to providing the restorations at UL4 and UR4 on 30 July 2020.
9	*As a result of your conduct at 8(a) and / or 8(b) and / or 8(d) and / or 8(e) above, you did not obtain the patient's valid consent for treatment.* **Found proved in relation to 8(d) and 8(e) (noting that 8(a) and 8(b) were found not proved).** In reaching its decision, the Committee accepted the opinion of Mr Dhami in relation to the obtaining of valid consent. Having considered all the evidence, the Committee was satisfied on the balance of probabilities that this allegation at 9 is proved in relation to 8(d) and 8(e). It concluded that you could not have obtained valid consent for treatment from Patient D having not taken any bite-wing radiographs to check the dental status of the teeth in question and to identify any dental pathology that may have needed addressing. In the absence of such information, the Committee considered that you could not have fully appraised Patient D of the risks and benefits of the tooth whitening treatment and the restorations you carried out. Therefore, whilst the Committee noted from the clinical records that Patient D did agree to the treatments, it was not satisfied that the consent you obtained was valid.
10(a)	*On or around 05 March 2020, you failed to maintain an adequate standard of record keeping for **Patient D** in that you did not record, adequately or at all:* *A BPE;*

	Admitted and found proved.
10(b)	*On or around 05 March 2020, you failed to maintain an adequate standard of record keeping for **Patient D** in that you did not record, adequately or at all:* *Dental charting;* **Admitted and found proved.**
10(c)	*On or around 05 March 2020, you failed to maintain an adequate standard of record keeping for **Patient D** in that you did not record, adequately or at all:* *Dental history.* **Admitted and found proved.**
Patient E	
11	*On 26 June 2020, you failed to provide an adequate standard of care to **Patient E** in that you did not diagnose and / or treat caries at the UR7 and / or LR6 and / or LL6.* **Found proved (as amended).** The Committee had regard to Mr Dhami's expert report in which he refers to an OPG radiograph taken of Patient E on 20 June 2020. He stated that the OPG showed radiolucencies at UR7, LR6 and LL6 *"that were indicative of caries".* Mr Dhami noted that you reported on this radiograph, but in his opinion, you failed to identify the caries. It was his opinion that the radiolucencies were "*clear and obvious".* In the clinical records for Patient E on 26 June 2020 it is noted, *"presence of caries: noted in the diagnosis".* However, under the relevant heading *"Findings & Diagnosis*, there is no reference to caries having been diagnosed. Furthermore, the patient's caries risk is noted as being *"low".* The Committee took into account your evidence that you recalled speaking to Patient E about the presence of caries. You stated that the patient told you that they preferred to return to see their own general dental practitioner regarding treatment of the caries, in order to save money. You stated that Patient E was only consulting you in respect of composite bonding. You maintained that the absence of a diagnosis of caries from the clinical records was due to a record keeping error. In reaching its finding, the Committee took into account that the clinical notes indicate that the patient had agreed to a recall examination at Practice 1 in six to 12 months *"in accordance with NICE Guidelines".* The Committee considered this contemporaneous information to be inconsistent with your recollection of the patient stating that they wished to return to their own dentist for routine treatment. The Committee also took into account that you meticulously recorded other clinical information in Patient E's clinical records.

	It was the view of the Committee that the absence of a diagnosis in the clinical records in respect of caries at UR7, LR6 and LL6 for 26 June 2020 is more likely because you did not diagnose the caries and therefore did not treat it.
Patient F	
12(a)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Did not carry out, adequately or at all, a BPE;* **Found not proved.** For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
12(b)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Did not complete, adequately or at all, dental charting;* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
12(c)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Did not undertake, adequately or at all, a dental history;* **Found proved.** The Committee found this allegation proved for the same reasons given previously. It had regard to the clinical records for Patient F and it found no record of a dental history. The joint expert opinion is that undertaking a dental history was a necessary component of the patient's examination on this date. The Committee took into account your evidence that it was your usual practice to obtain a full dental history from patients. However, given that there are detailed notes in the records in relation to other clinical matters, the Committee concluded on the balance of probabilities that you did not record a dental history because you did not take one from Patient F.
12(d)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Did not take any, or any adequate, bitewing radiographs;* **Admitted and found proved.**

12(e)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Took an OPG on 20 July 2020 which was of insufficient diagnostic quality;* **Admitted and found proved.**
12(f)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of care for **Patient F** in that you:* *Did not treat or plan to treat, active periodontal disease present;* **Admitted and found proved.**
13	*Your conduct at 12(a) and / or (f) above, exposed the patient at an increased risk of harm.* **Admitted and found proved in relation to 12(f) (noting that 12(a) was found not proved).**
14(a)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of record keeping for **Patient F** in that you did not record, adequately or at all:* *A BPE;* **Admitted and found proved.**
14(b)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of record keeping for **Patient F** in that you did not record, adequately or at all:* *Dental charting;* **Admitted and found proved.**
14(c)	*Between 19 July 2020 and 07 January 2021, you failed to maintain an adequate standard of record keeping for **Patient F** in that you did not record, adequately or at all:* *Dental history.* **Admitted and found proved.**
Patient G	
15(a)	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of care for **Patient G** in that you did not:* *Carry out, adequately or at all, a BPE;*

	Found not proved. For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
15(b)	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of care for **Patient G** in that you did not:* *Complete, adequately or at all, dental charting;* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
15(c)	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of care for **Patient G** in that you did not:* *Carry out a detailed / adequate orthodontic assessment.* **Found proved.** Patient G attended for Invisalign treatment. In his expert report, Mr Dhami stated that *"…if orthodontic treatment such as Invisalign is being considered a more detailed assessment of the occlusion is required".* Mr Dhami's set out in his report the components which he considers should be included in a full orthodontic assessment, namely the following: • *skeletal classification* • *incisal classification* - *overjet* - *overbite* • *canine classification* • *molar classification* • *crossbite* • *occlusal interferences* • *facial symmetry/asymmetry* • *face height/proportions* • *any deviation/displacement on opening closing* • *crowding* • *spacing displacement/rotation of teeth* • *missing teeth* • *patient's concerns and desires* It was Mr Dhami's opinion, taking into account the information recorded in your clinical records, that the orthodontic assessment you carried out for Patient G was not sufficiently detailed. He referred to it as a partial assessment.

	In your witness statement you acknowledged that the clinical records indicate that you carried out a partial assessment on 20 July 2020. You stated, however, that *"On 2 September, I took scans of the teeth. Invisalign itself requires a thorough digital scan (before treatment may progress), which provides a full orthodontic assessment that can be reviewed both before and during treatment. Invisalign treatment is based on high-resolution digital scans, which provide a clear record of the patient's occlusion and any existing malocclusions. These scans were used in treatment planning, meaning any orthodontic issues would have been assessed as part of the Invisalign workflow".* Mr McGrath, who agreed with the components set out by Mr Dhami in relation to a full orthodontic assessment, was questioned on whether a digital scan could be considered an alternative to a full orthodontic assessment. It was Mr McGrath's opinion that whilst a digital scan was a helpful adjunct to an orthodontic assessment, it did not replace the need for a full orthodontic assessment. The Committee was satisfied, having considered all the evidence, that you did not carry out a detailed or adequate orthodontic assessment in accordance with the requirements listed by Mr Dhami. It therefore found this head of charge proved on the balance of probabilities.
16(a)	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of record keeping for **Patient G** in that you did not:* *Record, adequately or at all, a BPE;* **Admitted and found proved.**
16(b)	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of record keeping for **Patient G** in that you did not:* *Record, adequately or at all, dental charting;* **Admitted and found proved.**
16c	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of record keeping for **Patient G** in that you did not:* *Record, adequately or at all, dental history;* **Admitted and found proved.**
16d	*Between 19 July 2020 and 22 January 2021, you failed to maintain an adequate standard of record keeping for **Patient G** in that you did not:* *Amend templated notes.* **Admitted and found proved.**
Patient H	
17(a)	*Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for **Patient H** in that you did not:*

	Carry out, adequately or at all, a BPE on 13 or 18 March 2020; **Found not proved (as amended).** For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
17(b)	*Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for **Patient H** in that you did not:* *Complete, adequately or at, dental charting on 13 or 18 March 2020;* **Found not proved (as amended).** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
17(c)	*Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for **Patient H** in that you did not:* *Take appropriate radiographs prior to undertaking tooth whitening on 01 July 2020*; **Admitted and found proved.**
17(d)	*Between 12 March 2020 and 04 September 2020 you failed to maintain an adequate standard of care for **Patient H** in that you did not:* *Report, adequately or at all, on the radiograph taken on 29 July 2020.* **Admitted and found proved.**
18	*As a result of your conduct at 17(a) and / or 17(c) above, you did not obtain the patient's valid consent for treatment.* **Admitted and found proved in relation to 17(c) (noting that 17(a) was found not proved).**
19(a)	*On or around 13 March 2020, you failed to maintain an adequate standard of record keeping for Patient H in that you did not record adequately or at all:* *A BPE;* **Admitted and found proved.**
19(b)	*On or around 13 March 2020, you failed to maintain an adequate standard of record keeping for Patient H in that you did not record adequately or at all:*

	Dental charting. **Admitted and found proved.**
Patient I	
20(a)	*Between 19 July 2020 and 16 January 2021 you failed to maintain an adequate standard of care for **Patient I** in that you did not:* *Carry out, adequately or at all, a BPE;* **Found not proved.** For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
20(b)	*Between 19 July 2020 and 16 January 2021 you failed to maintain an adequate standard of care for Patient I in that you did not:* *Complete, adequately or at all, dental charting.* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
21(a)	*Between 19 July 2020 and 16 January 2021, you failed to maintain an adequate standard of record keeping for **Patient I**, in that you did not record, adequately or at all:* *A BPE;* **Admitted and found proved.**
21(b)	*Between 19 July 2020 and 16 January 2021, you failed to maintain an adequate standard of record keeping for **Patient I**, in that you did not record, adequately or at all:* *Dental charting.* **Admitted and found proved.**
Patient J	
22(a)	*Between 15 January 2020 and 09 December 2020 you failed to maintain an adequate standard of care for **Patient J** in that you did not:* *Carry out, adequately or at all, a BPE;* **Found not proved.** For the same reasons set out at head of charge 2(a) above.

	The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
22(b)	*Between 15 January 2020 and 09 December 2020 you failed to maintain an adequate standard of care for **Patient J** in that you did not:* *Complete, adequately or at all, dental charting.* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
23(a)	*Between 15 January 2020 and 09 December 2020, you failed to maintain an adequate standard of record keeping for **Patient J** in that you did not record, adequately or at all:* *A BPE;* **Admitted and found proved.**
23(b)	*Between 15 January 2020 and 09 December 2020, you failed to maintain an adequate standard of record keeping for **Patient J** in that you did not record, adequately or at all:* *Dental charting.* **Admitted and found proved.**
Patient K	
24(a)	*Between 18 June 2020 to 08 January 2021, you failed to provide an adequate standard of care to **Patient K**, in that you:* *Did not complete, adequately or at all, dental charting on 19 June 2020;* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
24(b)	*Between 18 June 2020 to 08 January 2021, you failed to provide an adequate standard of care to **Patient K**, in that you:* *Took an OPG on 19 June 2020 which was of insufficient diagnostic quality;* **Admitted and found proved.**

24(c)	*Between 18 June 2020 to 08 January 2021, you failed to provide an adequate standard of care to **Patient K**, in that you:* *Did not diagnose and / or treat caries at the UR7 and / or UR8.* **Admitted and found proved.**
25	*On or around 19 June 2020, you failed to maintain an adequate standard of record keeping for **Patient K** in that you did not record, adequately or at all, dental charting.* **Admitted and found proved.**
Patient L	
26	*On or around 18 June 2020, you failed to maintain an adequate standard of record keeping for **Patient L** in that you did not record, adequately or at all, details of the appointment.* **Admitted and found proved.**
Patient M	
27(a)	*Between 19 July 2020 and 18 December 2020, you failed to provide an adequate standard of care to **Patient M**, in that you did not:* *Carry out, adequately or at all, a BPE on 20 July 2020;* **Found not proved.** For the same reasons set out at head of charge 2(a) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
27(b)	*Between 19 July 2020 and 18 December 2020, you failed to provide an adequate standard of care to **Patient M**, in that you did not:* *Complete, adequately or at all, dental charting on 20 July 2020;* **Found not proved.** For the same reasons set out at head of charge 2(b) above. The Committee was not satisfied that the GDC proved this allegation to the requisite standard.
27(c)	*Between 19 July 2020 and 18 December 2020, you failed to provide an adequate standard of care to **Patient M**, in that you did not:* *Diagnose and / or treat caries at the LL7.* **Admitted and found proved.**

28(a)	*On or around 20 July 2020, you failed to maintain an adequate standard of record keeping for **Patient M** in that you did not record, adequately or at all:* *A BPE;* **Admitted and found proved.**
28b	*On or around 20 July 2020, you failed to maintain an adequate standard of record keeping for **Patient M** in that you did not record, adequately or at all:* *Dental charting.* **Admitted and found proved.**
Other matters	
29(a)	WITHDRAWN.
29(b)	WITHDRAWN.
29(c)	WITHDRAWN.
30(a)	*On or before 22 February 2021 and at the time of the Covid-19 pandemic you failed to:* *Maintain adequate standards of cross infection control;* **Admitted and found proved.**
30(b)	*On or before 22 February 2021 and at the time of the Covid-19 pandemic you failed to:* *Adhere to rules of social distancing;* **Admitted and found proved.**
30(c)	*On or before 22 February 2021 and at the time of the Covid-19 pandemic you failed to:* *Ensure you were using Personal Protective Equipment ("PPE") correctly.* **Admitted and found proved.**
31	*As a result of your conduct at 30(a) and / or (b) and / or (c) above, you put patient safety at risk.* **Admitted and found proved.**
32(a)	*Between 01 July 2020 and 31 January 2021, you misappropriated monies from Company A by causing and / or allowing:* *Patients to pay money into your bank account; and / or* **Found proved.**

	The Committee bore in mind the definition of *'misappropriation'.* It is the unauthorised use of another person's property without their permission. The Committee heard from you about your contractual agreement with the original owners of Practice 1. In relation to the splitting of funds received from payments for treatment, you told the Committee that you received 45%, whilst the original owners of Practice 1 received 55%. Any payments required for laboratory fees were divided equally, with 50% of the fees to be paid by each party. Your oral evidence was consistent with the copy of your Associate Agreement placed before the Committee in relation to your work at Practice 1. You also told the Committee that when Company A took over Practice 1, you were not provided with a new contract and your existing contract with the original owners was not re-negotiated. The Committee had regard to the information in your Associate Agreement under the heading 'COLLECTION OF CHARGES AND FEES', where it is stated that *"The Company shall supervise the collection by practice staff of payments due from patients to the Associate in respect of dental attendance at the premises under private contract including fees due under the Denplan/Practice Plan scheme".* It was the conclusion of the Committee that by causing or allowing patients to pay money for their treatment directly into your bank account, you denied Company A its right to *"supervise"* the collection of payments in accordance with your Associate Agreement. The Committee noted the evidence of Witness 2 that it was not usual for patients to pay clinicians directly. Furthermore, it took into account the notes of your meeting with Witness 1 and other members of Company A on 3 February 2021, in which you are recorded as acknowledging that accepting money from patients by direct bank transfer or through Finance Company T was *"not in line with contract".* The Committee concluded that the GDC had discharged the burden on it to show that it was more likely than not that you misappropriated funds from Company A. This is because you were not authorised by your Associate Agreement or by Company A to receive money directly from patients, which was money that included the company's 55% share. During the time that the money was in your bank account, Company A could not supervise or account for the funds. In addition, there were no indications in the patients' clinical records that you had received direct payments, and there were no invoices or receipts of which Company A was made aware. For these reasons, the Committee found proved on the balance of probabilities that you misappropriated monies from Company A over the period in question.
32(b)	*Between 01 July 2020 and 31 January 2021, you misappropriated monies from Company A by causing and / or allowing:* *Patients to make payment through a finance company which was then paid into your bank account.* **Found proved.**

	For the same reasons set out above in respect of head of charge 32(a). The Committee concluded that the GDC had discharged the burden on it to show that it was more likely than not that you misappropriated funds from Company A. This is because you were not authorised by Company A to receive money from patients through Finance Company T, which was then paid into your back account. Accordingly, the Committee found proved that you misappropriated monies from Company A over the period in question.
33(a)	*Your conduct at 32 above was:* *Misleading, in that you were not entitled to receive monies from patients;* **Found proved.** The Committee was satisfied that your conduct in causing and/or allowing patients to pay money directly into your bank account, or to your bank account through Finance Company T, was misleading. The Committee considered that in the absence of any indications in the patients' clinical records that you had received the payments in these ways, and in the absence of any invoices or receipts of which Company A was made aware, Company A would have been misled into thinking that for the period of time in question, the expected payment processes were being followed, when they were not.
33(b)	*Your conduct at 32 above was:* *Dishonest, in that you knew the monies should have been paid directly to Company A.* **Found proved.** In considering your actual state of knowledge or belief as to the facts, the Committee was satisfied that you knew that your Associate Agreement, as it had been with the original owners of Practice 1, carried on under the ownership of Company A. This meant the continuation of the split of 45% and 55% in terms of payments received, with the equal division of any laboratory fees due. The Committee noted that you stated yourself at the meeting with Company A on 3 February 2021 that your conduct in receiving payments directly from patients and through Finance Company T was *"not in line with contract".* Furthermore, whilst the Committee noted your evidence that you had intended to repay Company A in full, it took into account that you did not do so until Company A's investigation into the financial irregularities had begun. By this time, the money had been in your bank account for some six months. The Committee noted from Witness 2's evidence regarding the repayment calculations that you repaid £69, 208.50, despite owing £63,835.04 to Company A. In relation to the delay in making repayment, you stated in your witness statement that *"The delay in doing so was purely an administrative oversight contributed to by an excessive workload, carrying out multiple roles in the Practice and my own disorganisation. These were clerical oversights, not acts of deception"*. However, the Committee considered that you would have had a sufficient amount of oversight over your bank account, in that you acknowledged receipt of some of the payments you received from

	patients, and you also stated that you received receipts from Finance Company T regarding payments made to you through them. The Committee concluded that the GDC had discharged the burden on it to show that it was more likely than not that you were dishonest because you knew that the money should have been paid directly to Company A, but it was not repaid until you were investigated several months later. In addition, the Committee concluded that the GDC had discharged the burden on it to show that, given your knowledge and beliefs, ordinary decent people would have considered your actions to have been dishonest. Accordingly, this allegation is found proved.
34	*On or around 03 February 2021 you told Company A that the diversion of patient funds to your bank account was directly linked to the suspension of patient finance.* **Found not proved.** Your evidence was that you accepted payments for treatment directly from patients as this was easier and more convenient for them for a number of reasons. The Committee noted that you stated in the meeting with Company A on 3 February 2021 that the majority of the payments you received through Finance Company T were in or around November 2020, when patient finance through Company A's chosen provider, Finance Company H, was suspended. However, acknowledging that you had been receiving payments from patients through Finance Company T since July 2020, which was before the suspension, you explained that Financial Company T had been more lenient in accepting patients' applications for finance, so you simply used them so that patients could start their treatment. Given the evidence of your explanations at the meeting on 3 February 2021, the Committee was not satisfied that the GDC proved on the balance of probabilities that you told Company A that the diversion of patient funds to your bank account was "*directly*" linked to the suspension of patient finance. Your reasons also included the leniency of Finance Company T in providing patient finance.
35	*The information provided to Company A as detailed at 34 above was incorrect.* **Found not proved.** In light of the Committee's finding at 34 above.
36(a)	*Your conduct at 34 above was:* *Misleading, as it suggested that funds had not been diverted until patient finance had been suspended;* **Found not proved.** In light of the Committee's finding at 34 above.
36(b)	*Your conduct at 34 above was:*

	Dishonest, as you knew the diversion of patient funds had begun before any patient finance had been suspended. **Found not proved.** In light of the Committee's finding at 34 above.
37	*For a period up until 03 February 2021 you stated on your social media page that you were a 'Dental Practice Owner'.* **Admitted and found proved.**
38(a)	*Your conduct at 37 above was:* *Misleading, as it suggested you owned a dental practice, when you did not;* **Admitted and found proved.**
38(b)	*Your conduct at 37 above was:* *Dishonest, as it was intended to convey that you owned a dental practice, when you did not.* **Found not proved.** In considering your actual state of knowledge or belief as to the facts, the Commiteee took into account the evidence that you were in the process of purchasing a dental practice around the time you stated on your social media page that you were a 'Dental Practice Owner'. The Committee had before it a Memorandum of Sale dated 30 July 2020, and it noted your evidence that between July 2020 and mid-January 2021, which is when you said you updated your social media page, processes were ongoing in relation to your purchase of the dental practice. You told the Committee that you were in *"an imminent position"* to being a Dental Practice Owner, and that you updated your social media page because you were *"exuberant and excited"* that your ownership was getting closer. You said that, in hindsight, you could see how referring to yourself as a Dental Practice Owner at a time when you did not officially own a dental practice, was objectively misleading. You stated, however, that you did not intend to mislead, but understood in hindsight that you should have waited. The Committee considered that ordinary decent people would take account of your evidence that you were very excited about purchasing a dental practice and had updated your social media page prematurely in that context. The Committee concluded that the GDC had not discharged the burden on it to show that ordinary decent people would consider your actions to have been dishonest in that context. Accordingly, the Committee found this allegation of dishonesty not proved.

40. The hearing now moves to Stage Two.

Stage Two of the hearing – 28 to 30 May 2025

41. The facts found proved in this case, many of which you admitted, relate to your clinical and record keeping failings in respect of 13 patients over a period of 11 months, from February 2020 to January 2021. At the material time, you were an Associate Dentist working for Company A at Practice 1.

42. The broad areas of clinical concern identified in the Committee's findings are in relation to:

- failing to take dental histories;
- no radiographs taken prior to treatment and when clinically appropriate;
- failures in obtaining valid consent;
- failures in diagnosis and treatment in relation to periodontal disease and caries. This included your admission that you exposed one patient to an increased risk of harm by not treating active periodontal disease.

43. There is also your failure in February 2021 to fully comply with guidance that was in place due to the Covid-19 pandemic. You admitted, and the Committee found proved, that you put patient safety at risk, in that you failed to maintain adequate standards of cross infection control, adhere to rules of social distancing and ensure that you were using PPE correctly.

44. Additionally, some non-clinical matters were found proved by the Committee. These included the Committee's finding, based on your own admission, that for a period of time up to 3 February 2021, you referred to yourself on your social media page as a 'Dental Practice Owner', when you did not in fact own a dental practice at that time. Whilst the Committee took into account that you were in the process of purchasing a dental practice, the sale had not been completed when you updated your social media page. You admitted, and the Committee found proved, that the premature updating of your social media page was misleading.

45. It was also found proved by the Committee that you misappropriated monies from Company A by receiving payments for treatment directly from patients into your company bank account or through a finance company, which was then paid into your company bank account. The Committee found your conduct in this regard to be misleading and dishonest, noting that you did not repay the money you owed to Company A until its investigation into the financial irregularities began. This was after you had held various amounts of money in your company bank account for several months, which should have been transferred directly to Company A.

Summary of parties' submissions at Stage Two – made on 28 May 2025

46. The Council originally alleged that your fitness to practise is impaired by reason of misconduct and/or deficient professional performance. However, in addressing the Committee on the matters to be considered at this second stage, Ms Vanstone submitted that the facts found proved all amount to misconduct, as opposed to deficient professional performance.

47. Ms Vanstone submitted that 'misconduct' is a word of general effect, involving some act or omission which falls short of what is proper in the circumstances. She submitted that the Committee could find that there was a serious departure from the GDC's *'Standards for the Dental Team'* (September 2013) ('the GDC Standards'). It was Ms Vanstone's submission that your conduct had breached the following GDC Standards: 1.3.1, 1.3.2, 1.3.3, 1.5.1, 2.2.1, 3.1.1, 4.1, 8.1 and 9.1.

48. Ms Vanstone also invited the Committee to have regard to the expert evidence, including the joint expert report of Mr Dhami and Mr McGrath, and to take into account their opinions regarding the level of your failures. She highlighted that a number of your failures were regarded by the experts as falling far below the expected standard. Ms Vanstone noted that Mr McGrath amended his opinion on some aspects of the joint expert report. However, she asked the Committee to take into account his oral evidence that, where there was potential for patient harm or where a certain clinical action was mandated, he would regard such failings as far below the expected standard. Ms Vanstone further highlighted Mr McGrath's opinion regarding certain isolated failures falling below standard, as opposed to far below, but that such failures, if repeated, could be considered as falling far below the expected standard. Ms Vanstone submitted that in all the circumstances, the Committee was invited to find that the facts found proved in this case amount to misconduct.

49. Ms Vanstone further invited the Committee to determine that your fitness to practise is currently impaired by reason of misconduct. She submitted that clinical concerns are remediable, but that probity concerns, which are attitudinal in nature, are more difficult to remedy, although not impossible. In relation to your clinical failings, Ms Vanstone acknowledged, having considered the remediation material provided at this stage, that the clinical shortcomings found proved are likely to have been remedied. Furthermore, if that view is taken, then it is unlikely that your clinical failings will be repeated.

50. However, in relation to the non-clinical concerns, Ms Vanstone submitted that there is less evidence of your reflective practice in relation to those matters. She submitted that it would be a matter for the Committee as to whether the material you have provided constitutes adequate remediation of the probity issues. The GDC's position, however, was that a finding of impairment is required in this case on wider public interest grounds, particularly given your misappropriation of monies from Company A and the associated finding of dishonesty.

51. Ms Vanstone said that your dishonesty continued over a period of some seven months. She drew the Committee's attention to the GDC's *'Guidance for the Practice Committees, including Indicative Sanctions Guidance'* (effective from October 2016; last updated in December 2020) ('the PC Guidance'), and outlined some aggravating factors which she said are present in this case. Ms Vanstone submitted that in all the circumstances, a suspension order was the only appropriate and proportionate sanction. She invited the Committee to consider suspending your registration for a period of 12 months, with a review.

52. In addressing the Committee, Mr Ivill submitted that the facts found proved do not amount to deficient professional performance, taking account of principles in *Calhaem, R (on the application of) v General Medical Council* [2007] EWHC 2606 Admin. The court said that deficient professional performance "…*connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of*

the doctor's work". Mr Ivill submitted that a fair sample of your work had not been provided. He said that the Committee had only been provided with clinical records for 13 patients, although you had seen about 800 patients over the 11 months in question. Mr Ivill calculated that this represented about 2% of your work over that time. He referred the Committee to the case of *Holton v General Medical Council* [2006] EWHC 2960 (Admin), in which more than 250 sets of medical records were considered in the assessment of the practitioner's clinical performance.

53. In relation to the issue of misconduct, Mr Ivill reminded the Committee that negligence does not amount to misconduct. He also submitted that there is a difference between 'misconduct' and 'serious misconduct', and that only serious misconduct could give rise to a finding of impairment. Mr Ivill submitted that the Committee should not cumulate instances of misconduct to reach a finding of serious misconduct and referred to paragraph 63 of *Schodlok v General Medical Council* [2015] EWCA Civ 769:

> *"…I do not think that we should opine on the theoretical possibility that, in a particular case on different facts, a series of non-serious misconduct findings could, taken together, be regarded as serious misconduct. For my part, I would not think that the possibility of taking such a course in a very unusual case on very unusual facts should be ruled out, but I would prefer to leave the argument for a case in which such facts were said to arise. In the normal case, I do not think that a few allegations of misconduct that are held individually not to be serious can or should be regarded collectively as serious misconduct."*

54. It was Mr Ivill's submission that this is not a very unusual case with very unusual facts, and he submitted that the threshold for serious misconduct has not been met in relation to the clinical matters found proved. Mr Ivill added that, even if the Committee were to determine that misconduct is made out on the clinical aspects, there is a wealth of material demonstrating that your clinical failings have been remedied and that your fitness to practise is not currently impaired on the basis of the clinical matters.

55. In relation to the non-clinical findings, Mr Ivill told the Committee that you accept that those matters fall short of the expected standards and that they are serious. He submitted that the conduct concerned is remediable, and he invited the Committee to consider the evidence of your remediation. Mr Ivill submitted that you have taken all the matters in this case seriously and you have worked hard to embed your remediation. He invited the Committee to take account of the lapse of time (of four years) since the concerns were raised, with no evidence of repetition. Furthermore, that you have demonstrated insight into the seriousness of your conduct, including in relation to the impact on patients, colleagues and public confidence in the dental profession. Additionally, Mr Ivill asked the Committee to take into account the fact of these rigorous fitness to practise proceedings which, he said, would further serve to uphold the wider public interest.

56. Mr Ivill submitted that if the Committee were to find current impairment, a short period of suspension would be appropriate and proportionate. He informed the Committee that you had initially been subject to an interim suspension order for a period of six months, from April to October 2021. He told the Committee that in October 2021, the interim suspension order was replaced with an interim conditions of practice order, which you have remained subject to for the last three and a half

years whilst waiting for this hearing. Mr Ivill asked the Committee to take this information into account when considering the length of any substantive suspension order.

57. Mr Ivill also asked the Committee to take into account that you have fully cooperated with the GDC and fully engaged with these proceedings. He further invited the Committee to have regard to the testimonials tendered on your behalf which, he submitted, clearly show that you are well-regarded. Mr Ivill submitted that it is in the public interest to retain the services of such a practitioner.

The Committee's decisions

58. In reaching its decisions at this second stage, the Committee considered all the evidence presented to it, both at the fact-finding stage and at this stage. The evidence received at this stage was a remediation bundle submitted on your behalf comprising your reflective statement prepared for this hearing, evidence of your Continuing Professional Development (CPD), a number of reports from your workplace supervisors under your interim conditions and character references.

59. The Committee took account of the submissions made by Ms Vanstone and by Mr Ivill in relation to deficient professional performance, misconduct, current impairment and sanction.

60. The Committee accepted the advice of the Legal Adviser in relation to all matters. It took into account that its decisions were for its independent judgement, there is no burden or standard of proof at this stage of the proceedings.

Decision in relation to deficient professional performance – 30 May 2025

61. The Committee first considered the issue of deficient professional performance. Counsel both submitted that the facts found in this case do not amount to deficient professional performance. However, the Committee heard and accepted the advice of the Legal Adviser that there is a distinction between conduct that amounts to misconduct – a serious departure from standards expected – and deficient professional performance, or a serious lack of competence. The Committee was advised that it needed to make a judgment as to which statutory ground (of potential impairment) is relevant, taking account of evidence heard, principles in judgments and submissions from both Counsel.

62. In reaching its decision, the Committee took account of principles in *Calhaem* brought to its attention by Mr Ivill. The Committee took account of the fact that, in this case, your clinical failings related to 13 patients. It also took account of your oral evidence at Stage One of the hearing, and Mr Ivill's undisputed submission that you would have seen around 800 patients over the 11 months in question.

63. Save in exceptional circumstance deficient professional performance must be demonstrated by reference to a fair sample of the registrant's work. Performance is unacceptably low if it departs from relevant professional standards: *Calhaem*. Having considered the requirement for a *"fair sample"* of your work, the Committee concluded that 13 patients out of a possible 800 is not a sample on which it could fairly assess your clinical practice over the 11 months concerned. Accordingly, the Committee determined that the threshold for deficient professional performance has not been met.

Decision on misconduct – 30 May 2025

64. The Committee went on to consider whether the facts found proved against you amount to misconduct. It took account of advice from the Legal Adviser that the word misconduct refers to behaviour that falls short of what can reasonably be expected of a professional. In *Meadow v General Medical Council* [2007] EWCA 1390 the appeal court said that *'misconduct' should not be viewed as anything less than 'serious professional misconduct'*.

65. In *Remedy UK v General Medical Council* [2010] EWHC 1245 the High Court said that misconduct is of two principal kinds. First, misconduct going to fitness to practise in the exercise of professional practice**.** Second, morally culpable or otherwise disgraceful conduct, outside or within professional practice. Conduct falls into the second category if it is dishonourable or attracts some kind of opprobrium – that fact may be sufficient to bring the profession into disrepute, and it does not matter whether it was directly related to the exercise of professional skills.

66. The Committee considered that a finding of misconduct in the regulatory context requires a serious falling short of the standards expected of a registered dental professional. The Committee had regard to the GDC Standards, and it was satisfied that the following are engaged in this case:

1.3.1 *You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.*

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

1.3.3 You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising.

1.5.1 You must find out about the laws and regulations which apply to your clinical practice, your premises and your obligations as an employer and you must follow them at all times. This will include (but is not limited to) legislation relating to:

- *…*
- *radiography*
- *…*
- *…*
- *…*

2.2.1 You must listen to patients and communicate effectively with them at a level they can understand. Before treatment starts you must:

- *explain the options (including those of delaying treatment or doing nothing) with the risks and benefits of each; and*
- *give full information on the treatment you propose and the possible costs.*

3.1.1 You must make sure you have valid consent before starting any treatment or investigation. This applies whether you are the first member of your team to see the patient or whether you are involved after other team members haven already seen them. Do not assume that someone else has obtained the patient's consent.

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

8.1 Always put patients' safety first.

9.1 Ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.

67. The Committee first considered its findings in relation to the clinical aspects of this case. In doing so, it considered all the matters found proved between heads of charge 2 to 31. This included the Covid-19 infection control issues that were found proved, as the Committee considered that these matters were directly related to your clinical practice.

68. The Committee had regard to the expert evidence. It noted that both Mr Dhami and Mr McGrath agreed that clinical failings that give rise to actual or potential harm to patients, are failings that they would regard as falling far below the expected standard. The Committee also took into account Mr McGrath's oral evidence regarding certain clinical actions being mandated.

69. The Committee concluded that your failings in diagnosis and treatment in relation to periodontal disease and caries, were serious failings for a dentist. It took into account the risk of harm to patients from leaving such dental conditions undiagnosed and therefore untreated. You admitted that you had exposed one patient to an increased risk of harm on account of not treating or planning to treat their periodontal disease. The Committee further took into account that both experts agreed that, if the Committee were to find proved your failings in diagnosis and treatment, that would, in their opinion, be conduct that falls far below what is expected in the circumstances.

70. The Committee also took account of the failings in your radiographic practice, in particular your failure to take appropriate radiographs prior to treatment. Both experts agreed that in the circumstances of the appointments concerned, bitewing radiographs were a necessary component of the pre-treatment investigations, including for the purpose of identifying any pathology. Accordingly, the Committee concluded that your failure to take appropriate radiographs were serious omissions.

71. It was further found by the Committee that in certain instances, the absence of pre-treatment investigations contributed to your failure to obtain valid consent for treatment. The Committee took into account Mr Dhami's opinion regarding the need for informed consent, and it agreed that consent needs to be informed to be valid. Mr Dhami maintained his opinion that a failure to obtain informed consent due to inadequate pre-treatment examinations falls below the expected standard. The Committee considered informed consent to be fundamental to the practice of dentistry, taking account of the GDC Standards, which make it clear that dental professionals must have valid consent before starting any treatment.

72. With regard to your failure to fully adhere to guidance during the Covid-19 pandemic in terms of adequate cross infection control, social distancing and the correct use of PPE, the Committee also considered and accepted the expert opinion that this is conduct that falls far below the expected standard. The Committee considered that it was made abundantly clear to everyone during the Covid-19 pandemic, particularly to healthcare professionals, what guidance and processes needed to be followed and why. The Committee considered that your ignoring of important regulations that were in place at the time, to protect colleagues and patients, would be condemned by colleagues and members of the public.

73. In relation to your record keeping, you admitted, and the Committee found proved, multiple instances where you failed to maintain adequate records in respect of patients' appointments, including in relation to BPEs, dental histories and dental charting. In considering the potential risk to patients from poor record keeping, the Committee had regard to Mr Dhami's opinion as set out in his expert report. He stated that, *"I would note, there may be occasions where dentists may fail to record a full examination due to time pressures or constraints, and therefore, whilst not ideal this would not fall far below the expected standard if it was an isolated incident. However, if a dentist fails to records details of appointments on multiple occasions across multiple patients, then this would constitute a very poor standard of record keeping overall, with the potential to affect patient's ongoing dental care and therefore the cumulative failure would fall far below the expected standard".* Taking this into account, given the significant number of your record keeping failings, the Committee considered that it could accept the expert opinion in this case that, when taken together, your record keeping failings repeated on multiple occasions across a number of patients, is conduct that falls far below the expected standard.

74. The Committee next considered the non-clinical matters found proved. Firstly, your misleading statement on your social media page about being a 'Dental Practice Owner', when you were not at the time. The Committee considered that this was behaviour that seriously breached your professional obligation for all advertising to be accurate and not misleading. In reaching its conclusion, the Committee took into account the context in which you updated your social media page, and that the statement was only in place for a short period of time. However, it considered that saying that you were a Dental Practice Owner when you were not, had potential to mislead the public and was highly unprofessional.

75. Lastly, the Committee considered the matter of your dishonesty. It was in no doubt that your dishonesty in misappropriating funds from Company A amounts to a serious falling short of the expected standards. Honesty and integrity are at the heart of the dental profession. Members of the public are entitled to expect that registered dental professionals act honestly in all that they do, to ensure that public confidence in the profession is maintained.

76. Having considered its findings, both clinical and non-clinical, the Committee determined that those matters set out at paragraphs 69 to 75 represent significant departures from what was expected of you in the circumstances. The Committee determined that the facts found proved amount to misconduct.

Decision on current impairment – 30 May 2025

77. The Committee next considered whether your fitness to practise is currently impaired by reason of your misconduct. In doing so, it had regard to the over-arching objective of the GDC, which is: the protection, promotion and maintenance of the health, safety, and well-being of the public; the promotion and maintenance of public confidence in the dental profession; and the promotion and maintenance of proper professional standards and conduct for the members of the dental profession.

78. The Committee took account of relevant legal principles, including those in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *CHRE v NMC and Grant [2011] EWHC 927 (Admin).* It asked the following questions:

> *"Do our findings of fact in respect of the [registrant's] misconduct… show that his/her fitness to practise is impaired in the sense that s/he:*
>
> > *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> >
> > *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> >
> > *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> >
> > *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future".*

79. The Committee first considered the clinical failings found proved. In its view, matters of a clinical nature are remediable. In assessing whether they have been remedied in this case, the Committee had regard to the evidence of your remediation, particularly in relation to the identified deficiencies in your clinical practice.

80. The Committee took into account the evidence of your CPD. It noted that you have undertaken a number of courses, over the past four years, focused on the areas of clinical concern. These included courses on infection control, communication, treatment planning for carious teeth, periodontal disease diagnosis, radiography, orthodontic treatment and clinical record keeping. The range of CPD certificates provided to the Committee are dated from November 2020 to January 2025. The Committee noted a positive development in your reflections on your learning.

81. The Committee was also provided with evidence of the work you have undertaken with your workplace supervisors. It had regard to the reports provided by them, including the most recent report dated 22 November 2024, in which your workplace supervisor positively reported on your clinical practice, confirmed that there have been no concerns, and stated that patients have been happy with their treatment. Your workplace supervisor said that *"His reviews reflect his dedication to communication and explaining treatments to patients".* The Committee also took into account the evidence of your work-based reflections and the open discussions that occurred between you and your workplace supervisors.

82. The Committee further considered your reflective statement written in relation to this case, in which you stated that *"…Dentistry is a profession I entered with pride and purpose, and it has been difficult to come to terms with the idea that my actions have led to concerns and contributed to a loss of trust in the profession. I take full accountability for my part in that. At the same time, this experience has instilled in me a far deeper understanding of the responsibilities I hold as a healthcare professional. It has reinforced that practising safely and ethically requires more than good clinical outcomes—it requires systems, structure, transparency, and continuous reflection. I currently understand, more than ever, documenting care in a detailed and contemporaneous manner, and ensuring that every treatment decision is well-justified and clearly communicated to the patient"*. You go on to set out in detail how you have changed your clinical practice which, you stated, included your pausing of all cosmetic dental work so that you could *"reflect deeply on the direction of my clinical focus".*

83. The Committee was impressed by the quality and standard of your remediation. It considered it clear from the material provided that you have insight into your past clinical shortcomings. This has been borne out by the focused steps you have taken to address the concerns. The Committee noted that you referred to the issue of your remediation during your oral evidence given at Stage One of the hearing, particularly in relation to your record keeping. The Committee also considered it evident that you have reflected on your treatment of the patients in this case over a long period of time. The Committee was satisfied on the basis of the evidence provided, which included objective evidence from your workplace supervisors, that you have embedded your learning into your practice. In the circumstances, it considered that any risk of repetition in relation to the clinical matters is low. The Committee therefore concluded that there are no ongoing patient safety concerns in this case.

84. The Committee was also satisfied that there are no outstanding public interest concerns arising from its clinical findings. It considered that the evidence of remediation, including your commendable personal reflections, demonstrate how seriously you have taken your clinical shortcomings and have given considerable thought to how your failings have impacted public confidence in the dental profession.

85. Having determined that there are no outstanding concerns in relation to the clinical aspects of this case, the Committee next considered the non-clinical matters relating to your conduct and behaviour.

86. The Committee considered the most serious aspect of your misconduct to be dishonesty. It also took account of the fact that you made a misleading statement on your social media page in 2021.

87. Dishonesty is an attitudinal concern and is therefore more difficult to remedy than concerns of a clinical nature, although it is not impossible. The Committee considered the evidence of your remediation in relation to the probity matters in this case, specifically your misappropriation of monies from Company A. It noted that you have undertaken a number of Legal and Ethics courses over the four years of your CPD, as well as a course on Developing Core Values. You also referred to your reflections on the GDC Standards, particularly Standard 9.1. The Committee noted that similarly, your reflections on what you had learned from this CPD improved over time.

88. You stated in your reflective statement provided for this hearing that one of the biggest lessons you have learned from this process is the importance of honesty and integrity. In particular, you stated that *"If a dentist fails to act with honesty and integrity, it can cause harm to public confidence, to colleagues who rely on you, and to the reputation of the profession as a whole. I've come to understand that honesty isn't just about telling the truth when asked, it's about being proactive, transparent, and consistent, even when it's uncomfortable*". You explained that in the past you made assumptions that led to poor decisions around process and record keeping. You stated that "*I did not set out to be dishonest, but I recognise that in some situations, I wasn't as open or structured as I should have been. Since then, I've worked hard to change, not just how I practise, but how I think. I've completed a Postgraduate Certificate in Dental Risk Mitigation, which focused heavily on professional integrity, and I've rebuilt my systems around transparency and accountability*".

89. The Committee considered your written reflections demonstrated a good understanding into how you came to make the decisions that you did around accepting payments for treatment directly from patients. The Committee also concluded that, since the relevant time, your appreciation of the importance of honesty and probity has developed.

90. The Committee considered questions b, c and d in *Grant*. The Committee considered that your dishonest actions breached a fundamental tenet of your profession and would undermine public confidence in dentistry. However, in light of your insight into the importance of probity, remediation and cooperation with these proceedings, the Committee considered any risk of repetition to be low.

91. However, the Committee went on to consider the wider public interest. Your dishonesty in misappropriating monies from Company A was serious and wholly unacceptable. The Committee considered that, because of your dishonesty, a finding of impairment is required to uphold proper professional standards and maintain public confidence in the dental profession

92. In conclusion, the Committee determined that your fitness to practise is impaired by reason of misconduct.

Decision on sanction – 30 May 2025

93. Having found your fitness to practise to be currently impaired, the Committee considered what sanction, if any, to impose on your registration. It bore in mind that the purpose of any sanction is not to be punitive, although it may have that effect, but to uphold the wider public interest. The Committee had regard to the PC Guidance. It applied the principle of proportionality, balancing the public interest with your own interests.

94. In considering the appropriate sanction, the Committee first identified what it considered to be the aggravating and mitigating features of this case.

95. In terms of aggravating factors, the Committee identified the following:

- Breach of trust.
- That your dishonesty was sustained over a period of time; the money you misappropriated from Company A remained in your bank account for several months.

96. In mitigation, the Committee took into account the following:

- Evidence of your previous good character.
- Lapse of time since 2021.
- Evidence of good conduct following the incident in question.

97. The Committee also had regard to the excellent character references tendered on your behalf. It took account of your reflections on the importance of probity.

98. Taking all the above into account, the Committee considered the available sanctions, starting with the least restrictive. The Committee noted that it was open to it to conclude this case without taking any action in relation to your registration, however, it considered that such a course would not serve to satisfy the wider public interest.

99. The Committee considered whether to issue you with a reprimand. In doing so, it took into account paragraph 6.9 of the PC Guidance. However, having taken into account the serious nature of your dishonesty, which was sustained over several months, the Committee concluded that a reprimand would not be sufficient to meet the wider public interest.

100. The Committee next considered whether to impose a conditions of practice order on your registration. It decided that conditional registration would not be appropriate, given the serious nature of dishonesty. The Committee determined that it could not formulate any workable or practical conditions that would address the issue of dishonesty.

101. The Committee went on to consider whether to suspend your registration for a specified period, up to a maximum of 12 months. In doing so, it had regard to paragraph 6.28 of the PC Guidance, which sets out factors relevant to the sanction of suspension. In this case, the Committee was satisfied that the following factors apply:

- There is evidence of repetition of the behaviour, in that your misappropriation of monies persisted over a period of time.
- Public confidence in the profession would be insufficiently protected by a lesser sanction.
- There is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order).

102. The Committee took into account that a suspension is appropriate for more serious cases, such as this one, which involves a sustained period of dishonesty. It further took into account that a

suspension order may be considered appropriate where some or all of the above factors from paragraph 6.28 of the PC Guidance apply, as they do in this case. However, in deciding whether a suspension order is appropriate and proportionate in all the circumstances, the Committee also had regard to paragraph 6.34 of the PC Guidance which deals with erasure.

103. The Committee noted that a number of the factors relevant to erasure are engaged in this case, in that there has been a serious departure from relevant standards, a breach of trust and dishonesty. The Committee considered that you have demonstrated insight into the importance of probity and honesty within the dental profession. It remained mindful of its duty to act proportionately, and taking into account all the circumstances of this case, the Committee concluded that the sanction of erasure would be disproportionate and punitive.

104. Accordingly, the Committee determined that the most appropriate, proportionate and necessary outcome is a six-month suspension. This is required to uphold standards and maintain public confidence in the profession. The Committee was satisfied that a six-month period is proportionate and sufficient to mark your dishonesty. In reaching its decision on the length of the suspension order, the Committee took account of the fact that your registration was suspended on an interim basis for six months in 2021, in the context of the principles in *Kamberova v The Nursing and Midwifery* Council [2016] EWHC 2955 (Admin).

105. The Committee took account of your reflections, which demonstrate an appreciation of the importance of probity and honesty in the dental profession, as well as the lack of any evidence of further concerns. The Committee does not direct a review in the circumstances of this case.

106. Unless you exercise your right of appeal, your registration will be suspended for a period of six months, starting 28 days from the date that notice of this Committee's direction is deemed to have been served upon you.

107. The Committee now invites submissions from Ms Vanstone and Mr Ivill, as to whether an immediate order of suspension should be imposed on your registration to cover the appeal period, pending the taking effect of the substantive order of suspension.

Decision on an immediate order – 30 May 2025

108. Having determined to impose a substantive order of suspension in this case, the interim order currently in place on your registration is hereby revoked.

109. In considering whether to impose an immediate order of suspension on your registration, the Committee took account of the submissions made by both Counsel.

110. Ms Vanstone did not apply for an immediate order on behalf of the GDC, given the Committee's determination that there are no ongoing patient safety concerns, and that the substantive order of suspension is imposed in the wider public interest only.

111. Mr Ivill submitted that an immediate order is neither necessary nor proportionate. He submitted that the wider public interest would be satisfied by the substantive order of suspension.

112. The Committee accepted the advice of the Legal Adviser and considered the statutory test for imposing an immediate order. It also took account of paragraphs 6.35 to 6.38 of the PC Guidance which deal with immediate orders.

113. The Committee determined that the imposition of an immediate order of suspension is not necessary in the absence of any ongoing public protection concerns. The Committee was satisfied that the substantive order of suspension is sufficient to uphold the wider public interest. It considered that immediate action is not required to protect public confidence in the profession or to maintain standards.

114. That concludes this determination.