HEARING HELD IN PUBLIC

Professional Conduct Committee
Initial Hearing

1-12 December 2025
18-19 March 2026

Name:	**Naz, Salma**
Registration number:	**286677**
Case number:	**CAS- 197655/198492/202103/205490**

General Dental Council:	Rebecca Vanstone, counsel Instructed by Kingsley Napley solicitors
Registrant: **F**	Present and not represented

Fitness to practise:	Impaired by reason of misconduct
Outcome:	Suspension for 3 months

Committee members:	Carson Black (Dentist) (Chair) Kam Sandhu (Lay) Emma Duke (Dental Care Professional)
Legal adviser:	Jane Kilgannon
Committee Secretary:	Jamie Barge

Ms Naz

1.This is a hearing before the Professional Conduct Committee (PCC). The hearing is being held remotely using Microsoft Teams in line with the Dental Professionals Hearings Service's current practice.

2.You are present and is not represented. Rebecca Vanstone of counsel appears for the GDC.

Preliminary matters –Application to amend the charges pursuant to Rule 18 – 3 December 2025

*3.*At the outset of the hearing, Ms Vanstone, on behalf of the GDC, made an application pursuant to Rule 18 of the *'General Dental Council (Fitness to Practise) Rules Order of Council 2006'*, referred to hereafter as 'the Rules', to make an amendment to the charges.

*4.*Ms Vanstone applied to withdraw Heads of charge 2, 3, 4, 5, 10, 21, 22, 23 and 24. She submitted that various attempts had been made to obtain the oral evidence of Patient 1 and 3, however, both have stated they are unable to give oral evidence for different reasons. Therefore, the GDC did not intend to rely on their evidence relating to those allegations.

*5.*You confirmed that you had no objection to the GDC's application to withdraw the charges as detailed.

*6.*The Committee heard and accepted the advice of the Legal Adviser.

*7.*Having regard to the merits of the case and the fairness of the proceedings, the Committee was satisfied that the required amendment could be made without injustice.

*8.*Therefore, the Committee accepted that Heads of charge 2, 3, 4, 5, 10, 21, 22, 23 and 24 are now withdrawn.

The charge

9.The charge that you face at this hearing as set out below, reads as follows:

1. *"*On or between 01 February 2020 and 06 February 2023 you provided dental services in connection with Practice 1 / Practice 2 and / or Practice 3.

<u>Patient 1</u>

2. WITHDRAWN:
    a. WITHDRAWN;
    b. WITHDRAWN;
    c. WITHDRAWN;
    d. WITHDRAWN;
    e. WITHDRAWN;
    f. WITHDRAWN;
    g. WITHDRAWN;
    h. WITHDRAWN;
    i. WITHDRAWN
    j. WITHDRAWN;
    k. WITHDRAWN;

l. WITHDRAWN.

3. WITHDRAWN.

4. WITHDRAWN.

5. WITHDRAWN:

a. WITHDRAWN;
b. WITHDRAWN;
c. WITHDRAWN;
d. WITHDRAWN;
e. WITHDRAWN;
f. WITHDRAWN.

Patient 2

6. On or between 06 July 2021 and 16 July 2021 you failed to maintain an adequate standard of care for Patient 2 in that you did not:

a. Carry out any or any adequate diagnostic assessments;
b. Ensure a clinical examination was carried out prior to the start of orthodontic treatment;
c. Adequately plan for treatment provided;
d. Take radiographs or arrange for radiographs to be taken, prior to recording that no dental decay was present;
e. Provide the patient with any, or any adequate, written plan for treatment;
f. Obtain an adequate medical history;
g. Adequately discuss alternative treatment options prior to treatment commencing;
h. Adequately discuss risks and/or benefits of treatment proposed;
i. Appropriately monitor the progress of the patient's treatment;
j. Ensure an examination was carried out prior to prescribing tooth whitening;
k. Monitor or plan to monitor tooth whitening treatment.

7. As a result of your conduct at 6(g) and / or 6(h) and / or 6(j) above, you did not obtain the patient's valid consent for treatment.

8. As a result of your conduct at 6(j) and / or 6(k) above, you exposed the patient to an increased risk of harm.

9. On or between 06 July 2021 and 16 July 2021 you failed to maintain an adequate standard of record keeping for Patient 2 in that you did not record and / or retain any or any adequate details of:

a. A written treatment plan;
b. The patient's medical history;
c. Clinical assessments undertaken;
d. Discussions relating to obtaining consent;
e. Treatment provided;
f. Photographs sent in by the patient.

Patient 3

10. WITHDRAWN:

a. WITHDRAWN;

b. WITHDRAWN;
c. WITHDRAWN;
d. WITHDRAWN;
e. WITHDRAWN;
f. WITHDRAWN.

Patient 4

11.On or between 01 July 2021 and 17 September 2021 you failed to maintain an adequate standard of care for Patient 4 in that you did not:

a. Carry out any or any adequate diagnostic assessments;
b. Ensure a clinical examination was carried out prior to the start of orthodontic treatment;
c. Adequately plan for treatment provided;
d. Provide the patient with any, or any adequate, written plan for treatment;
e. Obtain an adequate medical history;
f. Adequately discuss alternative treatment options prior to treatment commencing;
g. Adequately discuss risks and/or benefits of treatment proposed;
h. Appropriately monitor the progress of the patient's treatment;
i. Adequately respond to the patient's concerns about treatment progression;

12.As a result of your conduct at 11(f) and / or 11(g) above, you did not obtain the patient's valid consent for treatment.

13.On or between 01 July 2021 and 17 September 2021 you failed to maintain an adequate standard of record keeping for Patient 4 in that you did not record and / or retain any or any adequate details of:

a. A written treatment plan;
b. The patient's medical history;
c. Clinical assessments undertaken;
d. Discussions relating to obtaining consent;
e. Treatment provided;
f. Photographs sent in by the patient.

Patient 5

14.On or between 05 September 2019 and 30 January 2023 you failed to maintain an adequate standard of care for Patient 5 in that you did not:

a. Carry out any or any adequate diagnostic assessments;
b. Ensure a clinical examination was carried out prior to the start of orthodontic treatment and/ or when you took over the treatment;
c. Adequately plan for the treatment provided;
d. Take radiographs or arrange for radiographs to be taken;
e. Provide the patient with any, or any adequate, written plan for treatment;
f. Obtain an adequate medical history;
g. Discuss, adequately or at all, alternative treatment options;
h. Discuss, adequately or at all, risks and / or benefits of treatment;
i. Appropriately monitor the progress of the patient's treatment;
j. Ensure a clinical examination was carried out when the patient raised concerns about the progress of treatment.

15.As a result of your conduct at 14(c) and / or 14(g) and / or 14(h) above, you did not obtain the patient's valid consent for treatment.

16.On or between 05 September 2019 and 30 January 2023 you failed to maintain an adequate standard of record keeping for Patient 5 in that you did not record and / or retain any or any adequate details of:

a. A written treatment plan;
b. The patient's medical history;
c. Clinical assessments undertaken;
d. The orthodontic diagnosis;
e. Discussions of alternative treatment options and / or risks and benefits of treatment;
f. Treatment provided.

Patient 6

17.On or between 03 February 2020 and 06 February 2023 you failed to maintain an adequate standard of care for Patient 6 in that you did not:

a. Carry out any or any adequate diagnostic assessments;
b. Ensure a clinical examination was carried out prior to the start of orthodontic treatment;
c. Adequately plan for the treatment provided;
d. Take radiographs or arrange for radiographs to be taken;
e. Provide the patient with any, or any adequate, written plan for treatment;
f. Obtain an adequate medical history;
g. Discuss, adequately or at all, alternative treatment options;
h. Discuss, adequately or at all, risks and / or benefits of treatment;
i. Refer or plan to refer to a specialist orthodontist;
j. Provide correct advice to the patient regarding the fit of the aligners;
k. Ensure a clinical examination was carried out when the patient raised concerns about the progress of treatment.

18.As a result of your conduct at 17(c) and / or 17(e) and / or 17(g) and / or 17(h) above, you did not obtain the patient's valid consent for treatment.

19.Your conduct at 17(b) and / or 17(c) and / or 17(j) and / or 17(k) above, resulted in the treatment taking longer than was otherwise necessary.

20.On or between 03 February 2020 and 06 February 2023 you failed to maintain an adequate standard of record keeping for Patient 6 in that you did not record and / or retain any or any adequate details of:

a. A written treatment plan;
b. The patient's medical history;
c. Clinical assessments undertaken;
d. The orthodontic diagnosis;
e. Discussions of alternative treatment options and / or risks and benefits of treatment;
f. Treatment provided.

Other matters

21.WITHDRAWN

22. WITHDRAWN:
    a. WITHDRAWN
    b. WITHDRAWN.

23. WITHDRAWN.

24. WITHDRAWN:
    a. WITHDRAWN
    b. WITHDRAWN

25. On 14 September 2021 and / or 25 October 2021 you provided incomplete and / or inconsistent information to the GDC in respect of your employment history.

26. Your actions as set out at 25 above were:
    a. Misleading, in that:
        i. The dates provided of your employment with [Redacted] were inconsistent;
        ii. You did not reference your work at [Redacted] when submitting the '*Working arrangements and indemnity insurance'* form;
        iii. You did not reference your work with [Redacted] or with [Redacted] when submitting your CV.
    b. Dishonest.

27. Between February 2021 and September 2021 you permitted or allowed tooth whitening products to be given to patients without a prescription.

28. Your actions at 27 above:
    a. Put patients at an increased risk of harm;
    b. Caused unfair treatment of Colleague A, in that she was expected to breach tooth whitening regulations by providing these products.

And by virtue of those matters set out above, your fitness to practise is impaired by reason of your misconduct.

Background to the case and summary of allegations

10. The General Dental Council ("the Council") received four patient complaints with regard to remote orthodontic treatment they had received from Practice 2. This was followed by two further patient complaints regarding remote orthodontic treatment provided by Practice 1.

11. In outline it is alleged that you were the treating dentist in respect of those patients, it is alleged that you failed to provide an adequate standard of care, failed to obtain informed consent and failed to maintain an adequate standard of record keeping. In addition there are allegations relating to tooth whitening. It is further alleged that you provided inaccurate information to the GDC regarding your employment history and that this was misleading and/or dishonest.

12. The GDC subsequently commissioned two reports from a GDC expert, which were dated May and December 2024 and concluded that the standard of care provided by you to six patients was significantly below the level of professional Practice reasonably expected.

Admissions

13.At the outset of the hearing, you made a number of admissions to the allegations and detailed these admissions to the Committee. The admissions were in respect of heads of charge 25 and 26(a)(i)-(iii).

14.Having carefully considered each of your admissions detailed by you, and the supporting evidence for each of the admitted heads of charge, the Committee accepted your admissions and found those charges proved.

Evidence

15.The Committee has been provided with documentary material in relation to the heads of charge that you face. This material includes:

- The witness statements and documentary exhibits of the following witnesses:
  - Patient 1, dated 17 April 2024;
  - Patient 3, dated 17 April 2024;
  - Patient 4, 17 April 2024;
  - Colleague A, a dental nurse, dated 11 June 2024;
  - Aimee McLaughlan, GDC Caseworker dated 9 May 2024;
  - Patient 5 dated 15 November 2024;
- The expert reports of Giles Kidner, the GDC expert witness in this case, dated 13 May 2024 in respect of Patients 1 - 4 and a report dated 1 December 2024 in respect of Patients 5 and 6.
- Patient records of patients 1-6.

16.The Committee heard oral evidence from Patient 4, Colleague A, Patient 5 and the GDC expert witness.

Application for No Case to Answer under Rule 19(3) (9 December 2025)

17.At the conclusion of the GDC's case, you made a submission, that pursuant to Rule 19(3) of the Rules, there was no case for you to answer in respect of all the heads of charge.

18.The Committee received written submissions from both you and Ms Vanstone, and these were supplemented by oral submissions.

Your Submissions

19.You submitted that these submissions relate to the allegations relating to the following:

- The clinical allegations relating to the Practice 2 patients
- The clinical allegations relating to the Practice 1 patients
- The allegations in relation to tooth whitening
- The allegations in relation to dishonesty

20.In respect of the clinical records, you submitted that the GDC bear the burden of proving that you, rather than some other dentist or Practice 2 non-dental staff whether in India or elsewhere – had the responsibility at the relevant time specified in the allegations to

undertake the various steps which they allege were not taken. You submitted that the GDC has adduced no contemporaneous records of your involvement and no contemporaneous records of any other dentist's involvement.

21. You submitted that the GDC invited the Committee to infer that the absence of certain records from your papers is the consequence of such records never having been made. However, that requires the Council to discharge the burden of proving that, on the balance of probabilities, such records never existed. The Council has not done that. You invited the Committee to consider the following:

- The GDC's expert's acceptance that other records may have existed
- The GDC's expert's acceptance that after you left Practice 2 or Practice 1 the retention and security of the records rested with the businesses
- The GDC's expert has accepted that he could not access the hyperlinks in the Practice 2 records for Patients 2 and 4. It follows that what was or was not accessible via those links is a matter of speculation which the Committee cannot resolve.
- The GDC have failed to provide any evidence as to how the records were obtained, what enquiries were made, whether their statutory powers were deployed.
- The GDC's expert evidence is that Practice 2 went out of business.
- The GDC have adduced no evidence that the records were in your possession of control when they were requested by the GDC.
- The GDC have adduced no witness evidence from anyone with direct knowledge of how the records were created, identified and disclosed to the GDC.
- The GDC have adduced no audit trails for electronic records and no direct communications between you and either Practice 2 or Practice 1 in relation to the clinical care of these patients.
- The GDC have adduced no evidence of efforts to obtain such material or of its unavailability.
- The GDC has failed to pursue obvious lines of enquiry which were open to it e.g. Patient 4's indication that they had telephone recordings.
- The GDC failed to secure relevant evidence from Colleague A in the form of the tooth whitening protocol. That evidence is only before the Committee because you asked Colleague A and she happened to have retained it.
- The defects in the GDC's evidence were obvious and would have been apparent to the GDC well in advance of this hearing.

22. You submitted that in respect to your concerns raised with Dr Kidner during your questioning, he had ample time to reflect on them and to review the materials. Yet at the conclusion of his evidence his position was that he stood by his written report on the basis of the information he had at the time. You submitted that his report demonstrates no appetite to consider the possibility that you might be innocent. His oral evidence was, repeatedly, that he had assumed you were guilty.

23. You submitted that the Committee could have no confidence that Dr Kidner considered the material available to him with the diligence expected of an expert. They can have no confidence that his oral evidence was given with the benefit of having diligently considered the material available. Dr Kidner accepts that the expert's duties are an important aspect of fairness in the process. You invited the Committee to disregard Dr Kidner's evidence.

24. In respect of the clinical allegations relating to Patients 2 and 4, you submitted that proof of the allegations relating to Patients 2 and 4 each require the Council to prove – at a minimum - that you treated the patients to whom these allegations relate. You submitted that the GDC have adduced no direct evidence to support such a finding. Nor have the GDC adduced any evidence from which it could be inferred that you were involved in the treatment of these particular patients. You submitted that there is evidence that there were three dentists named on the Practice 2 website. The evidence which the GDC served in support of its case included evidence from Patient 3 that Practice 2 were conducting treatment without the involvement of any dentists.

25. In respect of Patient 2, you submitted that Patient 2 has not provided a witness statement.. In addition, you submitted that Patient 2 does not explain the basis for their assertion that "*My assigned dentist is Dr Salma Naz and her GDC# 286677*". In the circumstances that appears to be something which he was told by an unidentified third party. An email from 'S' at Practice 2 claims to cite '*the remarks of the dentist assigned to your treatment'* and sets out comments preceding the statement '*Remarks by Dr Salma Naz and her GDC#286677*.' You submitted that Patient 2 has no means to evaluate the accuracy or reliability of the information which he was provided with, and you added that nor does this Committee.

26. You submitted that the evidence, such as it is, is hearsay. It is not demonstrably reliable and it cannot be tested. No weight can properly be attached to it. That is so even before taking account of the wider evidence that Practice 2 was systematically deceptive in the information which they provided to patients. You submitted that there is a fundamental question as to whether 'S' was a real person – see pg.466 at 12/11/2021 22:06 "*'S' is not exist in Practice 2 I will make a selfi with all my college [sic] you can see there no 'S'*." You submitted that the allegations in relation to Patient 2 should not proceed.

27. In respect of Patient 4 you submitted that Patient 4 provides no direct evidence of who was involved in any particular aspect of their care and no direct evidence of your alleged involvement. It is clear that Patient 4's attribution of actions to you is based on information he was provided with by Practice 2 (Witness Statement para 5.) The source appears to be the email of 17 July 2021 from 'S' at Practice 2 which includes the following:

> "*The treatment plan we provide is signed-off by registered dentists in the UK and your assigned dentist is "Dr Salma Naz and her GDC# 286677*"

28. You referred the Committee to Patient 4's comment in his email of 16 July 2021 as follows: "*I have telephone recordings where it is stated the dentist is based at your labs abroad*". You submitted those recordings have not been adduced. You submitted that the comment aligns entirely with the evidence which has emerged from the workers in India. You submitted this evidence is hearsay and is not demonstrably reliable and it cannot be tested. No weight can properly be attached to it. You submitted that the allegations relating to Patient 4 should not proceed.

29. In respect of the clinical allegations relating to Practice 1, you submitted that proof of the allegations relating to Patients 5 and 6 each require the Council to prove that you treated the patients to whom these allegations relate. You submitted that the GDC have adduced no direct evidence to support such a finding.

30. You stated the GDC have provided no witness statement for patient 6. You submitted that Patient 5 merely describes his '*understanding*' based on your name appearing on packaging and a google search which he conducted. Neither of those is a sufficient basis to find that you were involved in Patient 5's care. You submitted that it is clear from the records that a significant proportion of the steps in Patient 5's treatment was the result of automated

processes – attributed in the noted to 'System'. You submitted that the GDC has adduced no evidence to explain the way in which those noted were created. The Committee has no evidential basis to determine that you were involved with any of those steps.

31. You submitted that Patient 6's records suggest that you had reviewed photos and approved him to move forward with treatment on 4 July 2022. The evidence, such as it is, is an email from an unidentified individual at Practice 1, not you. The author of that email has not been identified and has not been called to give evidence. There is no information available to the Committee as to the basis on which the author made reference to you. Your position is that you were not working with Practice 1 at that time.

32. In respect of your observations about Practice 1 noted, you highlighted that the records include columns for 'date', 'note', 'audience' and 'Input by'. The 'input by' column is populated either by 'agent' or 'system' or 'Provider' or 'Customer'. The actual identity of the person making the record is not recorded and the GDC have not investigated that issue. You submitted that the approval of Patient 5's treatment plan in September 2019 is attributed to 'Provider', therefore it cannot properly be assumed that references to 'Provider' are references to you.

33. You submitted that as to the reliability of Practice 1 as a source of evidence the Committee will note Colleague A's evidence which demonstrates that Practice 1 adopted an obstructive approach seeking to prevent Colleague A's concerns being shared with you. The Committee will also note Colleague A's evidence that the arrangements for tooth whitening were in place at Practice 1 before they were associated with you. You submitted that the allegations in relation to the Practice 1 witnesses should not proceed.

34. In respect of the tooth whitening allegations, you submitted that Colleague A's evidence is that it was "part of the [Redacted] procedure "*to do a teeth whitening demonstration, and at paragraph 12 she refers to Practice 1's 'policy'*. You submitted that she gives no evidence whatsoever of your involvement in the creation or implementation of that procedure. Nor does her statement provide any evidential basis for an inference that you knew of that procedure at the relevant time. You submitted that at paragraph 11 of her statement she refers to involvement of '*the manager, or deputy'*. She has clarified that those were individuals who were on site. The GDC has not sought to identify or interview any of them. You submitted that there is no evidence from Colleague A or elsewhere that you would have had the opportunity to see these cards bearing your name which are alleged to be prescription cards for tooth whitening, in use at Practice 1 shops.

35. You submitted that nowhere does Colleague A suggest that you were directly involved in the whitening procedure. You stated that Colleague A had a copy of the tooth whitening procedure. Colleague A has confirmed that a document of that sort was in existence during her first period of employment at Practice 1. You submitted that the GDC failed to secure that document and it was only as a consequence of your questions during her evidence that the procedure is in evidence. Therefore, you submitted that the GDC has not discharged the burden of proof in relation to allegations 27 or 28.

36. Finally, in respect of the allegations in relation to dishonesty, you submitted that the GDC rely solely on the evidence that the information provided by you was incorrect/incomplete. They have adduced no evidence of dishonesty and no evidence of motive and would require cogent evidence of dishonesty. You submitted that they have adduced none and for those reasons the allegation should not proceed.

Ms Vanstone's Submissions

37. Ms Vanstone, on behalf of the GDC, submitted that in respect of the clinical records, it is not accepted that the Council has not adduced any contemporaneous records of your involvement in the treatment of these patients. As an example, the records of patient 5 appear at p142 onwards. On the face of those records, they are contemporaneous. Those appearing at p195 onwards have recorded dates and times of entries. She submitted that entries refer to prescriptions having been issued by you, they evidence your involvement in the treatment. In the same way that a dental nurse may record entries for a dentist, it is not a requirement that the dentist themselves records their own actions, if they give cause to another to do so. On the face of the records, they are evidencing actions taken by you.

38. Ms Vanstone submitted that witnesses have been questioned by you on the basis that you were not involved in their treatment. It is difficult therefore, for you to say whether other records may or may not have existed, any more than Dr Kidner can. His acceptance that other records may have existed was because he believed the records were incomplete (that is, actions he would have expected to have been undertaken and recorded are not evidenced). Ms Vanstone submitted one of two scenarios is therefore at play: one, that the records were in existence but are now missing; or two, that those records were never made.

39. Ms Vanstone submitted that it is not a requirement for the Council to be able to show how the records were obtained, what enquiries were made, and whether their statutory powers were deployed in order to prove their case. She submitted clinical records are ordinarily self-serving. Whilst the Committee is entitled to attribute the weight it sees fit to those records, it should note that any suggestion that the records have been tampered with or falsified, is not a suggestion that is before the Committee in evidence at this stage. She submitted that it is accepted that there is no evidence that the records were in the possession or control of you at the time they were requested by the Council. This is not unusual. Records would always belong to the Practice rather than to the individual dentist.

40. Ms Vanstone submitted that the Council also disputes any suggestion that it failed to secure relevant evidence from Colleague A in the form of the tooth whitening protocol. It was not apparent on Colleague A's evidence that such a protocol existed, in circumstances where her evidence was that the managers 'standpoint' was that everyone was to be offered tooth whitening unless not suitable by the standards she explained and particularly where she had left the company three years prior to providing her statement.

41. Ms Vanstone submitted that in respect of the GDC's expert witness, he was asked to opine on the standard of clinical care afforded to the patients within the allegations referred by the Case Examiners. He sets out that '*It is understood that the Registrant was involved in overseeing the treatment that the patients were receiving'.* His report is written on that basis. At the time of writing his report(s), each of the patients named in the allegations referred by the Case Examiners had been told that you were their assigned dentist. It is not unreasonable for Dr Kidner to have proceeded on this basis.

42. Whilst Dr Kidner was cross-examined on the basis that he was neither fair nor objective, the substance of his criticisms regarding the standard of care provided to these patients was not challenged. It was not disputed that it was necessary to obtain an orthodontic assessment, a medical history, radiographs, take the patient through the consent process, and so on. The real objection expressed by you is that Dr Kidner assumed that you were the treating clinician, based on the evidence he considered, but you dispute that you were. The answer to that question requires a finding of fact by the Committee and that can only be done at the conclusion of stage 1.

43. In addition, Dr Kidner could not have been expected to amend the report he prepared for the Committee, upon receipt of a witness statement from you, served 18 months after the report

was written. He did accept in his oral evidence that the question of whether you were the clinician who provided care for these patients was in dispute, and that this was a matter of fact to be determined by the Committee. The Committee should not disregard Dr Kidner's evidence as invited to do so by you. In any event, this is not the opportunity to do so; matters of credibility should be left to the conclusion of the case and should not be determined at half time.

44. Ms Vanstone submitted that in respect of Patient 2, the Committee only has the records, but those should be considered alongside the evidence from the expert who is critical of the standard of care provided. There is an email within the records from Practice 2 saying that the patient's dentist is you and providing your GDC number. Ms Vanstone submitted that, whilst it is accepted that the email isn't from you, given you were working for the company at the relevant time and your name was provided, it is reasonable to infer that you were the treating dentist. There are comments attributed to you in respect of approving the treatment plan. She submitted that that establishes a prima facie case and one which the Committee could conclude, on one view, supports the allegations before you.

45. In respect of Patient 4, the evidence from patient 4 is that he was told a clinician was overseeing all stages of his treatment and when, later at around the time of his complaint, he asked who the dentist was, he was told it was you. It has not been challenged that this is what he was told by Practice 2. Whether the information that was given to him by Practice 2 was correct or not is a matter for the Committee to determine at the fact-finding stage, but it is not for determination at half time.

46. In respect of Patient 5, Ms Vanstone submitted that the patient has told the Committee that your name as the prescribing dentist was on the packaging of his aligners. He explained how he attended numerous "*touch-up*" appointments where refinements were made. In the records, the refinements are recorded as having been approved by you. Ms Vanstone submitted the allegations at their height are that patient 5 was told you were his assigned dentist, your name was on his aligners, and your name is in the records as having been involved in treatment. The expert evidence states that even if you did not approve the initial treatment plan, you had obligations to the patient at the point you took over his care. All of the above clearly establishes a case to answer.

47. In respect of Patient 6, Ms Vanstone submitted that whilst the Committee does not have direct evidence from patient 6, it does have numerous references in the records to you having taken a particular action. It is submitted that this is prima facie evidence that you were the clinician responsible for the care of this patient, when the records are considered together with the expert evidence. The case should proceed past half-time.

48. In respect of the tooth whitening allegations, Ms Vanstone submitted that the evidence is that tooth whitening products were being given to patients without being seen by a clinician. The card that the products were being provided with, had your name on. Another dentist's name was on the cards in 2020, but this was changed to your name by February 2021 when Colleague A returned to work for the company, having left the previous September. The fact that the provision of tooth whitening pens and the cards pre-dated your involvement with the company does not, contrary to the suggestion made, allow the Committee to conclude that you were not involved in the process once you were working with the company. The evidence before the Committee establishes a prima facie case that you were working for the company at the relevant time, your name was on cards which accompanied tooth whitening products given to patients who had not been assessed as being dentally fit for tooth whitening. The company's terms and conditions said that all whitening will be prescribed by a registered dentist, and you were not assessing those patients for suitability for tooth whitening.

49. Finally in respect of the dishonesty allegation, Ms Vanstone submitted that you have admitted that your conduct as set out at allegation 25 was misleading. The context of the misleading conduct must be looked at. She submitted that it must have been apparent to you, the importance of ensuring the information provided was correct. You would have been aware of the dates you had worked for various companies, you would have known all of your work history at the relevant time was being sought, and that it was important, when showing your work history, that all positions / roles were included within your CV. Ms Vanstone submitted that there is no requirement for the Council to prove evidence of motive to establish dishonesty. Whether the conduct was dishonest is a matter of consideration at the conclusion of the case. Ms Vanstone submitted that the Committee cannot, and should not, make that determination now.

Committee's Decision

50. The Committee accepted the advice of the Legal Adviser, and it applied the direction and test set out in the case of *R V Galbraith (1981) 1 WLR 1039*.

51. The Committee had regard to all the evidence thus far adduced. The Committee kept in mind throughout its decision making that the burden of proof rests entirely on the GDC and that it is not finding facts at this stage. The Committee was mindful that it must base its decision only on the evidence presented by the GDC. It took account of the written and oral submissions made by you, and those made by Ms Vanstone on behalf of the GDC.

52. The Committee considered that patients, 2, 4, 5 and 6, had raised complaints to the GDC, naming you as the dentist responsible for their treatment. Concerns included dissatisfaction with the treatment and poor communication. The Committee took into account the GDC statement in respect of direct-to-consumer orthodontic treatment and noted that all such treatment must be prescribed and monitored by a dentist after a face to face examination.

53. The Committee noted that you worked for both Practice 2 and Practice 1, but what is in dispute is the nature of your roles and responsibilities within those companies. Although it appears that none of the patients in question met you in person, the Committee noted that some of the patients had been advised that you were the treating dentist, and for some of the patients your name appeared in their records, on the packaging and on prescription cards. You dispute the validity of the documentary records and the information communicated to patients. You stated that you were never responsible for any of the 4 patients referenced in the heads of charge.

54. The Committee considered the totality of the GDC's evidence and considered each of the individual allegations in that context.

55. When deciding whether any or all of these charges could be proven, the Committee considered the following 3 questions.

- Is there no evidence at all upon which the Committee could find the particular allegation proved?

- Is there some evidence, but the quality of that evidence is of such an unsatisfactory character (for example, the quality of the evidence is so inherently weak, vague or inconsistent with other evidence) that the Committee, taking the evidence at its highest and properly directed as to the burden and standard of proof, could not find the allegation proved?

- Is there some evidence, the relative strength or weakness of which is dependent upon the Committee's view of the reliability of a witness or other evidence such that, on one possible view of that evidence, the Committee could find the allegation proved?

56. The Committee then considered all of the remaining heads of charge and determined whether it had been presented with sufficient evidence from the GDC, that when taken at its highest could result in charges being found proved.

57. In respect of Patient 2, it noted there are limited records available. The Committee noted the email of 12 July 2021, from a representative of the company that states that you had reviewed the case and listed the recommendations made. It noted that you were engaged by the company at the relevant time. The Committee was also mindful of the expert report listing the responsibilities of treating dentists.

58. The Committee decided that the documentation, together with the expert report, amounted to some evidence in support of the relevant allegations, but the relative strength or weakness of that evidence was dependent on its view of the reliability of the documents which it could only determine at the close of the fact-finding stage, having heard all of the evidence available. The Committee accepted, however, that when taken at its highest, one possible view of that evidence could permit the allegations to be found proved

59. The Committee then considered heads of charge regarding Patient 4. There is evidence within email correspondence to Patient 4 from the company where he was told by the company that you were his responsible dentist. In oral evidence Patient 4 also confirmed that the company told him that you were overseeing his treatment. The Committee decided that the email correspondence, together with the expert report, amounted to some evidence in support of the relevant allegations, but the relative strength or weakness of that evidence was dependent on its view of the reliability of the documents which it could only determine at the close of the fact-finding stage, having heard all of the evidence available. The Committee accepted, however, that when taken at its highest, one possible view of that evidence could permit the allegations to be found proved.

60. The Committee then considered heads of charge regarding Patient 5. There is evidence that your name appeared in records relating to Patient 5's treatment and the packaging for the aligners. The Committee decided that this documentation, together with the expert report, amounted to some evidence in support of the relevant allegations, but the relative strength or weakness of that evidence was dependent on its view of the reliability of the documents which it could only determine at the close of the fact-finding stage, having heard all of the evidence available. The Committee accepted, however, that when taken at its highest, one possible view of that evidence could permit the allegations to be found proved.

61. In respect of Patient 6, the Committee noted there is no live evidence nor a witness statement from this patient. However, the Committee noted the web complaint form which specifically references you as being the treatment provider. In addition, there are references in the patient noted, particularly 12 October 2021, stating you as being involved in the patient's treatment. The Committee decided that this documentation, together with the expert report, amounted to some evidence in support of the relevant allegations, but the relative strength or weakness of that evidence was dependent on its view of the reliability of the documents which it could only determine at the close of the fact-finding stage, having heard all of the evidence available. The Committee accepted, however, that when taken at its highest, one possible view of that evidence could permit the allegations to be found proved.

62. In respect of head of charge 1, the Committee considers that having found there is a case to answer in respect of the allegations relating to patients 2, 4, 5 and 6, it is satisfied that there is sufficient evidence that you may have been involved in the treatment of patients at Practice

1/Practice 2 and/or Practice 3 at the relevant dates. For the same reasons as above, the Committee determined that when taken at its highest, one possible view of the evidence could permit the allegation to be found proved.

63. In respect of head of charge 26(b) regarding alleged dishonest conduct, the Committee noted that you have admitted that your conduct in this respect was misleading. The Committee was satisfied that the provision of misleading information to the GDC during its investigation was sufficient for there to be a prima facie case of dishonesty.

64. The Committee also considers that in respect of heads of charge 27 and 28, there is some evidence linking you with tooth whitening treatment at Practice 1. The Committee noted Colleague A's evidence that your name was on the prescription cards provided with the tooth whitening kits at Practice 1. The Committee decided that the evidence from Colleague A, together with the expert report, amounted to some evidence in support of the relevant allegations, but the relative strength or weakness of that evidence was dependent on its view of the reliability of that evidence which it could only determine at the close of the fact-finding stage, having heard all of the evidence available. The Committee accepted, however, that when taken at its highest, one possible view of that evidence could permit the allegations to be found proved.

65. The Committee, therefore, rejected your No Case to Answer application in respect of all the outstanding heads of charge in this case.

66. After handing down the determination on this application on 10 December 2025, the Committee then heard oral evidence from you the following day.

Committee's findings of fact

67. The Committee has taken into account all the evidence presented to it, both written and oral. The Committee has considered the submissions made by Ms Vanstone on behalf of the GDC and those from you. It has had regard to the GDC's *Guidance for Practice Committees including Indicative Sanctions Guidance (October 2016, updated December 2020)*.

68. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee is mindful that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, namely, the balance of probabilities. In relation to the dishonesty allegation, the Committee was reminded of the test set out in *Ivey v Genting Casinos (UK) Limited* [2017] UKSC 67 and the guidance in the recent case of *Alam v GMC* [2025] EWHC 2907 (Admin).

69. The Committee has considered each head of charge separately.

70. I will now announce the Committee's findings in relation to each head of charge.

1.	On or between 01 February 2020 and 06 February 2023 you provided dental services in connection with Practice 1 / Practice 2 and / or Practice 3. **Proved** You told the Committee, and it was not challenged by the GDC, that Practice 1 and Practice 3 were the same entity trading under different names. On the balance of probabilities, the Committee accepted that to be the case. The Committee placed significant weight on your written and oral evidence that you had performed some clinical duties for these three companies/Practices.

	In your written and oral evidence, you accepted that you had acted as an approver of orthodontic treatment plans for Practice 1, Practice 2 and Practice 3 at the relevant times, as part of company-wide dental teams. You stated your role was to approve treatment plans. The arrangement was ad hoc and at times you would access a portal, retrieve the treatment plans which you would review and approve or reject. You stated that you never had any face-to-face contact with patients and thought that you were part of a wider team and that it was others who took responsibility for the treatment. You said that you thought that your role was merely to check suitability of treatment plan although you admit now that you had been naive. The Committee noted that this was consistent with other documentation available, for example, an email from your solicitor dated 12 January 2022 confirming that you were in the process of bringing your "*relationship*" with Practice 1 / Practice 3 to an end. The Committee was satisfied that approving orthodontic treatment plans amounted to the provision of dental services. The Committee therefore concluded that you provided dental services in connection with Practice 1 / Practice 2 and/or Practice 3 between 1 February 2020 and 6 February 2023. The Committee therefore finds this head of charge proved.
	Patient 1
2.	**WITHDRAWN**
2.a	**WITHDRAWN**
2.b	**WITHDRAWN**
2.c	**WITHDRAWN**
2.d	**WITHDRAWN**
2.e	**WITHDRAWN**
2.f	**WITHDRAWN**
2.g	**WITHDRAWN**
2.h	**WITHDRAWN**
2.i	**WITHDRAWN**
2.j	**WITHDRAWN**
2.k	**WITHDRAWN**
2.l	**WITHDRAWN**
3.	**WITHDRAWN**
4.	**WITHDRAWN**

5.	**WITHDRAWN**
5.a	**WITHDRAWN**
5.b	**WITHDRAWN**
5.c	**WITHDRAWN**
5.d	**WITHDRAWN**
5.e.	**WITHDRAWN**
5.f.	**WITHDRAWN**
	Patient 2
6.	On or between 06 July 2021 and 16 July 2021 you failed to maintain an adequate standard of care for Patient 2 in that you did not:
6.a	Carry out any or any adequate diagnostic assessments; **Not proved** You told the Committee that you had no recollection of treating Patient 2 and therefore deny that you were the patient's treating dentist. There was no witness statement from Patient 2 and they were not called to give oral evidence. In their complaint form, Patient 2 indicated "*I am not able to ascertain who is my actual dentist however…*". Patient 2 stated "I have asked several times *which of the 3 dentists has actually been overseeing my treatment, again not been given this information and referred back to the websites 3 dentists…I have overall concern that the stages of treatment are not actually been checked by a qualified dentist…* ". The Committee noted the email dated 12 July 2021 from Practice 2 to Patient 2 which included what appeared to be an excerpt from the system notes. It used technical dental terminology and was signed off "*Remarks by Dr Salma Naz*" and your GDC registration number. However, the email is signed off by someone called "*Sarah*" and that person has not provided a witness statement or been called to give evidence. As a result, the Committee has not been able to ask them questions about the circumstances in which they included those remarks and attributed them to you. Given that context, the Committee did not consider it to be appropriate to give that email any great weight. There were no other records that appeared to link you to Patient 2. The GDC expert confirmed in his oral evidence that his analysis of the care provided to Patient 2 had been undertaken on the assumption that you were the treating dentist for Patient 2, but he accepted that it was a matter that was in dispute for the Committee to resolve. Given the weakness of the evidence linking you to the dental care of Patient 2, the Committee was not satisfied that the GDC has discharged the burden of proving that you were the treating dentist for Patient 2. Given that you were not

	the treating dentist for Patient 2, it could not be said that you had failed to maintain an adequate standard of care for them, failed to obtain their valid consent for treatment, exposed them to an increased risk of harm, or failed to maintain an adequate standard of record keeping for them. The Committee therefore found these heads of charge not proved.
6.b	Ensure a clinical examination was carried out prior to the start of orthodontic treatment; **Not proved.**
6.c	Adequately plan for treatment provided; **Not proved.**
6.d	Take radiographs or arrange for radiographs to be taken, prior to recording that no dental decay was present; **Not proved.**
6.e	Provide the patient with any, or any adequate, written plan for treatment; **Not proved.**
6.f	Obtain an adequate medical history; **Not proved.**
6.g	Adequately discuss alternative treatment options prior to treatment commencing; **Not proved.**
6.h	Adequately discuss risks and/or benefits of treatment proposed; **Not proved.**
6.i	Appropriately monitor the progress of the patient's treatment; **Not proved.**
6.j	Ensure an examination was carried out prior to prescribing tooth whitening; **Not proved.**
6.k	Monitor or plan to monitor tooth whitening treatment. **Not proved.**
7	As a result of your conduct at 6(g) and / or 6(h) and / or 6(j) above, you did not obtain the patient's valid consent for treatment. **Not proved.**

8.	As a result of your conduct at 6(j) and / or 6(k) above, you exposed the patient to an increased risk of harm. **Not proved.**
9.	On or between 06 July 2021 and 16 July 2021 you failed to maintain an adequate standard of record keeping for Patient 2 in that you did not record and / or retain any or any adequate details of:
9.a	A written treatment plan; **Not proved.**
9.b	The patient's medical history; **Not proved.**
9.c	Clinical assessments undertaken; **Not proved.**
9.d	Discussions relating to obtaining consent; **Not proved.**
9.e	Treatment provided; **Not proved.**
9.f	Photographs sent in by the patient. **Not proved.**
	Patient 3
10.	**WITHDRAWN**
10.a	**WITHDRAWN**
10.b	**WITHDRAWN**
10.c	**WITHDRAWN**
10.d	**WITHDRAWN**
10.e	**WITHDRAWN**
10.f	**WITHDRAWN**
	Patient 4
11.	On or between 01 July 2021 and 17 September 2021 you failed to maintain an adequate standard of care for Patient 4 in that you did not:
11.a	Carry out any or any adequate diagnostic assessments; **Not proved.** You told the Committee that you had no recollection of treating Patient 4 and therefore deny that you were the patient's treating dentist.

	Patient 4 provided a witness statement and gave oral evidence. Patient 4 confirmed that they were treated by Practice 2 but they never met their treating dentist and they have never had any interaction with you. They confirmed that they were not given your name by Practice 2 until an email dated 17 July 2021. Both your full name and GDC registration number were given. However, the email is signed off by someone called "*Sarah*" and that person has not provided a witness statement or been called to give evidence. As a result, the Committee has not been able to ask them questions about the circumstances in which they told Patient 4 that you were their treating dentist. Given that context, the Committee did not consider it to be appropriate to give that email any great weight. There were no other contemporaneous records that appeared to link you to Patient 4. Patient 4 told the Committee that the communications from Practice 2 appeared to be automated, in that he was often given generic responses like his treatment was heading in the right direction, and to "*please keep using chewies*" even when that did not make sense as an answer to his question. The Committee noted Patient 4's complaint letter which cast doubt as to whether any dentist was involved with his treatment. In his complaint, Patient 4 alleges untruthfulness in correspondence received from the practice and stated… "…*To summarise the process I would make the following observations* *1) The [Practice 2] team are regularly untruthful in verbal communications to which I have recorded evidence* *2) The [Practice 2] team rely upon automated, or largely autogenerated responses to client communications in relation to their treatment plans.* *3) The [Practice 2] team are woefully uneducated in the information they provide through their website and again there is much evidence to support this* *4) The [Practice 2] team claim to supervise and direct treatment. The nature of the above, the commonality in responses, and the lack of personal feedback suggests this process is automated also (and may not be supervised by the dental practitioner* *5) The lack of follow up and diligence in relation to my reasonable questions related to progress is unacceptable and shows again a lack of judgement (or supervision)…."* The GDC expert confirmed in his oral evidence that his analysis of the care provided to Patient 4 had been undertaken on the assumption that you were the treating dentist for Patient 4, but he accepted that it was a matter that was in dispute for the Committee to resolve. Given the weakness of the evidence linking you to the dental care of Patient 4, the Committee was not satisfied that the GDC has discharged the burden of proving that you were the treating dentist for Patient 4. Given that you were not the treating dentist for Patient 4, it could not be said that you had failed to maintain an adequate standard of care for them, failed to obtain their valid consent for treatment, or failed to maintain an adequate standard of record keeping for them. The Committee therefore found these heads of charge not proved.
11.b	Ensure a clinical examination was carried out prior to the start of orthodontic treatment;

	Not proved.
11.c	Adequately plan for treatment provided; **Not proved.**
11.d	Provide the patient with any, or any adequate, written plan for treatment; **Not proved.**
11.e	Obtain an adequate medical history; **Not proved.**
11.f	Adequately discuss alternative treatment options prior to treatment commencing;
11.g	Adequately discuss risks and/or benefits of treatment proposed; **Not proved.**
11.h	Appropriately monitor the progress of the patient's treatment; **Not proved.**
11.i	Adequately respond to the patient's concerns about treatment progression; **Not proved.**
12	As a result of your conduct at 11(f) and / or 11(g) above, you did not obtain the patient's valid consent for treatment. **Not proved.**
13.	On or between 01 July 2021 and 17 September 2021 you failed to maintain an adequate standard of record keeping for Patient 4 in that you did not record and / or retain any or any adequate details of:
13.a	A written treatment plan; **Not proved.**
13.b	The patient's medical history; **Not proved.**
13.c.	Clinical assessments undertaken; **Not proved.**
13.d	Discussions relating to obtaining consent; **Not proved.**
13.e	Treatment provided; **Not proved.**

13.f	Photographs sent in by the patient. **Not proved.**
	Patient 5
14.	On or between 05 September 2019 and 30 January 2023 you failed to maintain an adequate standard of care for Patient 5 in that you did not:
14.a	Carry out any or any adequate diagnostic assessments; **Not proved** You told the Committee that you had no recollection of treating Patient 5 and therefore deny that you were the patient's treating dentist. You stated that the patient's treatment started in September 2019 and you could not have been the assigned clinician at this point as you were not registered with the GDC until November 2019. The Committee noted that there were Practice 1 records relating to Patient 5, which were dated within the relevant period, and which referenced you by name. These had the appearance of administrative records rather than clinical records. They were organised chronologically and included an "*input by*" column to indicate who had added the record to the system. The Committee noted that all of the references to you were inputted by "*system*" or "*agent*", rather than a named individual. GDC has not provided any evidence to assist the Committee in identifying who made those entries in the record – no witness statement has been provided and they have not been called to give evidence. As a result, the Committee has not been able to ask them questions about the circumstances in which they made reference to you as the treating dentist of Patient 5. The Committee also noted that Practice 1 appeared to have continued referring to you in emails to other patients even after it was clear that you had stopped working for the company. Given that context, the Committee did not consider it to be appropriate to give the records in question any great weight. That context significantly undermined the reliability of the records and emails. Patient 5 provided a witness statement and gave oral evidence. Patient 5 told the Committee that your name appeared on the packaging for their aligners as their prescribing dentist and that he had noticed your name on Practice 1's website after doing an online search. Patient 5 stated "*I understand my treatment was overseen by two dentists; first by Salma Naz and second by a separate dentist. This was not confirmed with me by [Practice 1] but I was able to find out the dentist overseeing treatment was Salma Naz by doing an online search and because her name was listed on the packaging of my aligners as the prescribing dentist. I no longer have this packaging".* As with the records considered above, the Committee had no information as to how your name came to be added to the aligner packaging so it did not consider it to be a reliable indicator that you actually were Patient 5's treating dentist. In relation to the mention of your name on the Practice 1 website, the Committee had no information that the reference linked you to Patient 5, only to the company (Practice 1) itself.

	The GDC expert confirmed in his oral evidence that his analysis of the care provided to Patient 5 had been undertaken on the assumption that you were the treating dentist for Patient 5, but he accepted that it was a matter that was in dispute for the Committee to resolve. Given the weakness of the evidence linking you to the dental care of Patient 5, the Committee was not satisfied that the GDC has discharged the burden of proving that you were the treating dentist for Patient 5. Given that you were not the treating dentist for Patient 5, it could not be said that you had failed to maintain an adequate standard of care for them, failed to obtain their valid consent for treatment or failed to maintain an adequate standard of record keeping for them. The Committee therefore found these heads of charge not proved.
14.b	Ensure a clinical examination was carried out prior to the start of orthodontic treatment and/ or when you took over the treatment;
14.c	Adequately plan for the treatment provided; **Not proved.**
14.d	Take radiographs or arrange for radiographs to be taken; **Not proved.**
14.e	Provide the patient with any, or any adequate, written plan for treatment; **Not proved.**
14.f	Obtain an adequate medical history; **Not proved.**
14.g	Discuss, adequately or at all, alternative treatment options; **Not proved.**
14.h	Discuss, adequately or at all, risks and / or benefits of treatment; **Not proved.**
14.i	Appropriately monitor the progress of the patient's treatment; **Not proved.**
14.j	Ensure a clinical examination was carried out when the patient raised concerns about the progress of treatment. **Not proved.**
15.	As a result of your conduct at 14(c) and / or 14(g) and / or 14(h) above, you did not obtain the patient's valid consent for treatment. **Not proved.**
16.	On or between 05 September 2019 and 30 January 2023 you failed to maintain an adequate standard of record keeping for Patient 5 in that you did not record and / or retain any or any adequate details of:
16.a	A written treatment plan; **Not proved.**
16.b	The patient's medical history; **Not proved.**

16.c	Clinical assessments undertaken; **Not proved.**
16.d	The orthodontic diagnosis; **Not proved.**
16.e	Discussions of alternative treatment options and / or risks and benefits of treatment; **Not proved.**
16.f	Treatment provided. **Not proved.**
	Patient 6
17.	On or between 03 February 2020 and 06 February 2023 you failed to maintain an adequate standard of care for Patient 6 in that you did not:
17.a	Carry out any or any adequate diagnostic assessments; **Not proved.** You told the Committee that you had no recollection of treating Patient 6 and therefore deny that you were the patient's treating dentist. There was no witness statement from Patient 6 and they were not called to give oral evidence. In their GDC complaint form dated 13 July 2022 under "*professional name*", Patient 6 listed Practice 1 and you. The Committee noted that there were numerous Practice 1 records relating to Patient 6, which were dated within the relevant period, and which referenced you by name. These had the appearance of administrative records rather than clinical records. It was unclear from the records, however, who was inputting each of the entries. It was variously "*Dental Team OBE*" or not attributed at all. GDC has not provided any evidence to assist the Committee in identifying who made the relevant entries in the records – no witness statement has been provided, and they have not been called to give evidence. As a result, the Committee has not been able to ask them questions about the circumstances in which they made reference to you in relation to the treatment of Patient 6. The Committee also noted that Practice 1 appeared to have continued referring to you in emails to Patient 6 even after it was clear that you had stopped working for the company. Given that context, the Committee did not consider it to be appropriate to give those records and emails any great weight. That context significantly undermined the reliability of the records and emails. The GDC expert confirmed in his oral evidence that his analysis of the care provided to Patient 6 had been undertaken on the assumption that you were the treating dentist for Patient 6, but he accepted that it was a matter that was in dispute for the Committee to resolve. Given the weakness of the evidence linking you to the dental care of Patient 6, the Committee was not satisfied that the GDC has discharged the burden of proving that you were the treating dentist for Patient 6. Given that you were not the treating dentist for Patient 6, it could not be said that you had failed to maintain an adequate standard of care for them, failed to obtain their valid consent for treatment, caused their treatment to take longer than was otherwise

	necessary, or failed to maintain an adequate standard of record keeping for them. The Committee therefore found these heads of charge not proved.
17.b	Ensure a clinical examination was carried out prior to the start of orthodontic treatment; **Not proved.**
17.c	Adequately plan for the treatment provided; **Not proved.**
17.d	Take radiographs or arrange for radiographs to be taken; **Not proved.**
17.e	Provide the patient with any, or any adequate, written plan for treatment; **Not proved.**
17.f	Obtain an adequate medical history; **Not proved.**
17.g	Discuss, adequately or at all, alternative treatment options; **Not proved.**
17.h	Discuss, adequately or at all, risks and / or benefits of treatment; **Not proved.**
17.i	Refer or plan to refer, to a specialist orthodontist; **Not proved.**
17.j	Provide correct advice to the patient regarding the fit of the aligners; **Not proved.**
17.k	Ensure a clinical examination was carried out when the patient raised concerns about the progress of treatment. **Not proved.**
18.	As a result of your conduct at 17(c) and / or 17(e) and / or 17(g) and / or 17(h) above, you did not obtain the patient's valid consent for treatment. **Not proved.**
19.	Your conduct at 17(b) and / or 17(c) and / or 17(j) and / or 17(k) above, resulted in the treatment taking longer than was otherwise necessary. **Not proved.**
20.	On or between 03 February 2020 and 06 February 2023 you failed to maintain an adequate standard of record keeping for Patient 6 in that you did not record and / or retain any or any adequate details of:
20.a	A written treatment plan; **Not proved.**
20.b	The patient's medical history; **Not proved.**
20.c	Clinical assessments undertaken; **Not proved.**

20.d	The orthodontic diagnosis; **Not proved.**
20.e	Discussions of alternative treatment options and / or risks and benefits of treatment; **Not proved.**
20.f	Treatment provided. **Not proved.**
	Other matters
21.	**WITHDRAWN**
22.	**WITHDRAWN**
22.a	**WITHDRAWN**
22.b	**WITHDRAWN**
23	**WITHDRAWN**
24.	**WITHDRAWN**
24.a	**WITHDRAWN**
24.b	**WITHDRAWN**
25.	On 14 September 2021 and / or 25 October 2021 you provided incomplete and / or inconsistent information to the GDC in respect of your employment history. **Admitted and found proved.**
26.	Your actions as set out at 25 above were:
26.a	Misleading, in that:
26.a.i	The dates provided of your employment with [REDACTED] were inconsistent; **Admitted and found proved.**
26.a.ii	You did not reference your work at [REDACTED] when submitting the 'Working arrangements and indemnity insurance' form; **Admitted and found proved.**
26.a.iii	You did not reference your work with [REDACTED] or with [REDACTED] when submitting your CV. **Admitted and found proved.**
26.b	Dishonest. **Proved in respect of 26.a.ii.** **Not proved in respect of 26.a.i and iii.**

You admitted that on 14 September 2021 and on 25 October 2021 you provided incomplete and/or inconsistent information to the GDC in respect of your employment history and that your actions were misleading, in that:

i. The dates provided of your employment with (Practice 2) were inconsistent;
ii. You did not reference your work at (Practice 3) when submitting the 'Working arrangements and indemnity insurance' form; and
iii. You did not reference your work with (Practice 2) or (Practice 3) when submitting your CV.

The Committee first considered the information that you provided to GDC on 14 September 2021 – the 'Working arrangements and indemnity insurance' form that you sent to GDC by email. The incomplete and/or inconsistent and misleading information in that form was that you:

i. Stated in Box 1 (places of work between May 2021 and July 2021) that you had worked for Practice 2 from May 2021 to July 2021, even though you worked for Practice 2 from May 2020 to 19 August 2021; and
ii. Failed to mention either in Box 1 (places of work between May 2021 and July 2021) or Box 2 (current places of work) that you had worked for Practice 3.

Applying the first stage of the test from *Ivey v Genting Casinos*, the Committee considered what your state of mind was when you sent the form with that misleading information to GDC on 14 September 2021. The Committee bore in mind that you are of previous good character, which makes it less likely that you would have acted dishonestly as alleged, and less likely that you would have been untruthful about your state of mind in submitting the misleading information.

You told the Committee that the misleading information was included in the form in error because you were stressed about being investigated by your regulator. In support of that assertion you brought to the Committee's attention the fact that you made an obvious error on the form, in that you stated that you had only worked for the clinic in Dublin as an Associate Dentist from May 2021 to July 2021 when, in fact, you had worked there from 2017 and remained in that post.

Given that the questions on the form submitted on 14 September asked where you had worked between May and July 2021, you appeared to have listed Practice 2 correctly and confirmed that you worked there for the full period between those dates. With this in mind, the Committee found the most likely explanation was that you thought that you were answering honestly despite the fact that it appears to have given a misleading impression of the full period of time where you worked for Practice 2. The Committee notes that in answer to the same question, you provided the same dates for the practice where you were an associate and elsewhere on the form recorded the full dates that you had worked there. Therefore, the Committee concluded that your state of mind when answering this question was honest in that you did not have an intent to mislead.

In the same form in answer to where you worked between May and July 2021 and where you worked currently, you had failed to mention that you had worked for Practice 3 since November 2019. You also failed to mention your work at another remote aligner dentistry company in Dublin, although that is not subject

to any heads of charge. The Committee's view is that the way in which you completed the form for GDC had been deliberately misleading. You knew that the GDC was investigating a complaint about you relating to remote aligner companies, and these omissions from the form effectively concealed the fact that you had worked and continued to work for these two remote aligner companies. The Committee considered this was more likely than not an attempt by you to conceal or minimise the extent of your involvement in remote aligner companies.

Applying the second stage of the test from *Ivey v Genting Casinos,* the Committee found that an ordinary decent member of the public would find your conduct

- in relation to the inconsistent dates relating to Practice 2 not to be dishonest because you did not have an intent to mislead, and;
- in relation to the omission of Practice 3 to be dishonest because it was a deliberate attempt to conceal or minimise the extent of your involvement with remote aligner practices while that was being investigated by your regulator.

The Committee next considered the information that you provided to GDC on 25 October 2021 – your CV. The incomplete and/or inconsistent and misleading information in that CV was that you omitted to mention your work for Practice 2 or Practice 3.

Applying the first stage of the test from *Ivey v Genting Casinos*, the Committee considered what your state of mind was when you sent the CV with that misleading information to GDC on 25 October 2021.

You told the Committee that you did not intend to provide misleading information to the GDC. You said that you were asked for information about your work history for an upcoming Interim Orders Committee (IOC) hearing and you simply sent a CV that you had available saved electronically. You said that it was unfortunate that you didn't check it before sending it to GDC to ensure that it was up to date. You stated that it was submitted in a rush, early on the morning of the date scheduled for an IOC hearing. The Committee notes that was consistent with the email from your Solicitor providing your CV and another document at 08.04am on 25 October 2021. You stated there was no intention to mislead because the missing information – your work for Practice 2 and/or Practice 3 – was already known to GDC and you were aware that they knew about it.

The Committee accepted your account of your state of mind in relation to the provision of the CV. It was consistent with the available documentary evidence. It was not in dispute that there had been a first IOC hearing on 5 October 2021 and a second scheduled for 25 October 2021 (but later rescheduled and held on 28 October 2021). The Committee noted that GDC had sent an email to your solicitors dated 29 September 2021 asking for a copy of your employment details due to some discrepancies between the information they held on file and the information that you had already provided to your solicitors. The Committee noted that your solicitors then sent an email to GDC on 4 October 2021, appearing to attach a copy of your CV, and then a further email on 25 October 2021 attaching what appears to be the same CV document and a testimonial document.

The Committee considered that the fact that you had been dishonest when submitting some of the misleading information on 14 September 2021 made it

	more likely that you had a dishonest intent when submitting the misleading information on 25 October 2021. However, the Committee decided that, although it made it more likely, it was not enough to persuade it given the relevant facts. The Committee was satisfied that the most likely explanation of what happened was that you were asked for information about your work history for the IOC hearing and you provided an old CV in haste without properly checking whether or not it was up to date. In doing so, you acted carelessly but not with a deliberate intention to mislead by concealing your work for Practice 2 and/or Practice 3. Applying the second stage of the test from *Ivey v Genting Casinos,* the Committee found that an ordinary decent member of the public would not find your conduct on that occasion to be dishonest because you made a genuine mistake, without any intention to mislead. Given the guidance of the High Court in the recent case of *Alam v GMC* [2025] EWHC 2907 (Admin) for cases where a Committee is considering making mixed findings of honest and dishonest conduct in relation to a registrant who is of previous good character, the Committee stepped back to look at the whole picture in order to check that its reasoning had taken into account: a. the inherent improbability of someone with previous good character acting dishonestly rather than in error; and b. the inherent improbability of someone switching from an honest state of mind to a dishonest state of mind in a short space of time. The Committee was satisfied that it had properly considered these matters. The reason for the '*mixed picture'* findings was that on 14 September 2021 the Committee believes that you would have understood the need to give accurate information and yet you gave inaccurate information omitting to mention your work at Practice 3. You also knew at that time that the GDC was investigating a complaint relating to a remote aligner company, but there is no evidence that you knew whether GDC was aware that you had been working for Practice 3. Therefore, it could be inferred that concealing that information could be to your advantage and was your motivation in failing to disclose it. The circumstances were different five-six weeks later, on 25 October 2021, when you sent your CV to GDC. At that point it would have been clear to you that GDC already knew that you had worked for Practice 2 and / or Practice 3 because IOC hearings had been arranged to consider complaints relating to Practice 2 (IOC hearing on 5 October 2021) and Practice 3 (IOC hearing on 25/28 October 2021). The Committee therefore found this head of charge; • not proved in relation to 14 September 2021 (Charge 26(a)(i)); • proved in relation to 14 September 2021 (Charge 26(a)(ii));and • not proved in relation to 25 October 2021 (Charge 26(a)(iii)).
27.	Between February 2021 and September 2021 you permitted or allowed tooth whitening products to be given to patients without a prescription. **Not proved.** Colleague A, who is a registered dental nurse and worked for Practice 1at the relevant times, provided a witness statement and gave oral evidence. They told

	the Committee that during the relevant period Practice 1 was routinely, and without a prescription, giving out 'goody bags' to patients which contained tooth whitening products together with a 'prescription card' with your name on it. Colleague A told the Committee that she did not think that any dentist was involved in prescribing the tooth whitening products or the treatment planning more generally. She described the Practice 1 systems as murky. The Committee noted that the Practice 1 consent forms referenced tooth whitening. However, when looking at the way in which it was referenced in the consent form, the Committee was not persuaded that that would have been enough to alert you to the fact that Practice 1 smile shops were giving out tooth whitening products without prescription. You told the Committee that you were not aware that tooth whitening products were being given to patients without prescription and that you did not permit or allow it. You told the Committee that as soon as you became aware of it, you emailed Practice 1 and asked them to stop. You provided the Committee with a copy of that email, which was dated 6 October 2021, in which you state "*As we discussed yesterday, I was absolutely unaware of whitening pen been dispensed in smiles shops for every over 18 years old patient. Can we please stop that immediately as its not under GDC guidelines and I wasn't aware that it's given under my name*". The Committee considered that this contemporaneous email was consistent with your account that you were unaware that Practice 1 was giving tooth whitening products to patients without a prescription. On that basis, the Committee was satisfied that you neither permitted nor allowed that practice at Practice 1. The Committee therefore found these heads of charge not proved.
28.	Your actions at 27 above:
28.a	Put patients at an increased risk of harm; **Not proved** This head of charge falls away having found head of charge 27 not proved.
28.b	Caused unfair treatment of Colleague A, in that she was expected to breach tooth whitening regulations by providing these products. **Not proved.** This head of charge falls away having found head of charge 27 not proved.

71. We move to stage two.

Determination on misconduct, impairment and sanction – 19 March 2026

72. Following the handing down of the Committee's findings of fact on 15 January 2026, the hearing proceeded on 18 March 2026 to 'stage two'; that is to say, misconduct, impairment and sanction.

Proceedings at stage two

73. The Committee has considered all the evidence presented to it, both oral and written. It has taken into account the submissions made by Ms Vanstone on behalf of the GDC and those made by you. The Committee has accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard.

74. In its deliberations the Committee has had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). Although the Committee notes that that guidance was replaced part-way through the hearing on 6 January 2026 by a new guidance document, namely *Fitness to Practise: Guidance for the practice committees* (January 2026), the Committee has adopted the former guidance at this hearing, as it was extant at the start of the hearing.

Evidence at stage two

75. The Committee at this stage of the hearing received a written reflective and remediation statement from you, a copy of an email dated 18 March 2026 relating to your record keeping Continuing Professional Development (CPD), an email between the GDC and your legal representative dated 29 September 2021, and copies of (CPD) certificates. The Committee noted that you had already presented testimonials at stage 1 of the proceedings, and they were taken into account also at this stage.

Summary of submissions

76. Ms Vanstone on behalf of the GDC submitted that the facts that the Committee has found proved amount to misconduct. She submitted that you have provided inconsistent and incomplete information during the GDC's investigation by way of your working arrangements form. She submitted that by concealing that you had worked for two other remote aligner companies, it was to your advantage. She submitted that the conduct was serious. Even though there is only one instance of proven dishonesty, misleading conduct in respect of providing information during the course of the GDC's investigation is also serious. Ms Vanstone submitted that providing incorrect information to your regulatory body is a serious departure from the standards expected, in particular those of Principle 9 specifically, 9.1 and 9.4. She submitted that whilst misleading conduct may not always reach the threshold for a finding of misconduct, in the context of this case, your conduct does amount to conduct that would be considered to be deplorable. Ms Vanstone submitted that each of the matters found proved were serious enough to amount to misconduct.

77. Ms Vanstone submitted that your fitness to practise is currently impaired by reason of that misconduct. She submitted not to making a finding of impaired fitness to practise would undermine public interest. Ms Vanstone submitted you have provided a number of CPD certificates. Some may have some relevance such as the course on professionalism and integrity. However, this was a 45 minute online course completed last Sunday (15 March 2026). She submitted that before today, reflective evidence of what you learnt on that course, or reflections on courses undertaken in October 2025, had not been provided to the Committee. In addition, there is no recognition of any steps in place to ensure there is no repetition of this conduct. She submitted that given the recent CPD courses undertaken, this Committee cannot be satisfied that this recent learning and any reflections have been embedded at this stage. Ms Vanstone submitted that this Committee cannot be satisfied that what you have provided demonstrates true remediation. She submitted that your fitness to practise is impaired.

78. Ms Vanstone submitted that you have demonstrated dishonest conduct towards the GDC. Although this was only a single event (14 September 2021), the misleading conduct was repeated again on 25 October 2021. She submitted any insight that may be present has not yet been fully developed. Ms Vanstone invited the Committee to consider that a period of suspension of 3 months with a review is the appropriate and proportionate sanction in this case on the wider public interest ground. She submitted that the purpose of the review would be to assess whether insight had been fully developed.

79. You submitted that you rely on the testimonials provided and that the authors had been updated on the findings made at stage 1 of these proceedings. You asked the Committee to rely on these testimonials to show that your conduct found proved was out of character. However, you stated you do not seek to rely on these as evidence on your current insight. You did not provide oral submissions and stated that you rely on your written submissions. You accepted that the finding of dishonesty was serious enough to amount to a finding of misconduct, but you submitted the other matters found proved were not. In respect of impairment, and in light of the context and evidence of remorse, insight and remediation, you invited the Committee to consider the risk of repetition was low. You submitted that a sanction of a reprimand would be the appropriate and proportionate action to take in this case.

80. In response to questions from the Committee, you stated you acknowledge you have not provided reflections on your CPD learning on courses such as "Professionalism and ethics". However, after Committee questions you provided a written reflections document to the Committee. You stated that you respect the Committee's findings, and that the finding of dishonesty is a source of shame and embarrassment, and you are fully committed to ensuring your conduct in future will fully uphold the values of integrity and honesty. You stated that your intent was never to be misleading or dishonest. You stated that you now recognise the importance of being honest and transparent with your regulator.

Fitness to practise history

81. Ms Vanstone addressed the Committee in accordance with Rule 20 (1) (a) of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). Ms Vanstone stated that you have no previous fitness to practise history with the GDC.

Misconduct

82. The Committee first considered whether the facts that it has found proved at heads of charge 1, 25, 26.a i-iii, and 26.b constitute misconduct. In considering this, the Committee has exercised its own independent judgement.

83. In its deliberations the Committee has had regard to the following paragraphs of the GDC's *Standards for the Dental Team* (September 2013) in place at the time of the incidents giving rise to the facts that the Committee has found proved. These paragraphs state that as a dentist you must:

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.

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

84. The Committee determined that heads of charge 1, 25, 26.a i and iii, were not so serious as to amount to misconduct, but head of charge 26.b in relation to 26.a.ii did amount to misconduct. Head of charge 1 was simply an admission that you worked at Practice 1 / Practice 2 and / or Practice 3 at the relevant times. The Committee determined that your dishonest conduct was so serious as to amount to misconduct. However, the Committee determined that the other misleading conduct was not so serious as to amount to misconduct, as it was careless but not intentional.

85. In respect of your dishonest conduct, albeit one single incident, the Committee is satisfied that this was a very serious failing particularly in the context of regulatory proceedings. The

Committee considers that acting with honesty and integrity with the GDC regulator is a basic and fundamental tenet of the profession. You deliberately withheld information from your regulatory body and deprived the GDC of the full, timely and accurate information that it had requested in connection with fitness to practise investigation and also before an Interim Orders hearing. The Committee considers that such conduct could have placed the public at risk of harm and you have undermined trust and confidence in the profession.

86. The Committee has determined that the proven facts at head of charge 26.b in respect of 26.a.ii. amounts to misconduct. The Committee considers that your conduct was a serious falling short of the standards reasonably to be expected of a registered dentist.

Impairment

87. The Committee next considered whether your fitness to practise is currently impaired by reason of the misconduct that it has found. In doing so, the Committee again exercised its own independent judgement. Throughout its deliberations, the Committee has borne in mind that its overarching objective is to protect the public, which includes the protection of patients and the wider public, the maintenance of public confidence in the profession and in the regulatory process, and the declaring and upholding of proper standards of conduct and behaviour.

88. The Committee notes that, since the incidents giving rise to these proceedings occurred, you have attended some relevant and targeted CPD courses, such as Honesty, Professionalism and Integrity, Ethics and Business. The Committee also recognises your genuine remorse and that these proceedings have had a salutary effect on you. It also took into account that the dishonest conduct occurred over 4.5 years ago, was an isolated incident, and there is no evidence of repetition. The Committee accepted that the dishonest conduct was out of character based on the testimonials provided, the lack of evidence of repetition and your oral submissions.

89. The Committee noted your reflection that "I *recognise that my actions fell below the standard expected of a registered dental professional, and I deeply regret the distress and time this matter has caused to the regulator and to the profession. I accept that the finding of dishonesty made by the Committee is a serious one. It is a source of shame, pain and embarrassment for me and I am fully committed to ensuring that my conduct in the future will fully uphold the values of integrity, honesty and trustworthiness. This process, and the Committee's finding of dishonesty, has made me reflect deeply on the importance of probity in professional practice. I now understand more clearly that accuracy, honesty and transparency in dealings with the regulator are fundamental obligations, not administrative formalities. The regulator must be able to rely on registrants to provide full and accurate information at all times"*. On the basis of your reflection, the Committee was satisfied that you have fully understood the gravity of your misconduct, and its potential impact on the regulator and public confidence in the profession.

90. The Committee considers that your conduct is remediable in this situation, relating as it does to specific and identifiable aspects of your conduct towards the GDC. Having had careful regard to all of the information placed before it, the Committee considers that you have produced sufficient evidence to demonstrate that you have remedied your misconduct to the required extent. In the circumstances, the Committee finds that repetition of your misconduct is highly unlikely. The Committee therefore finds that your fitness to practise is not impaired on the grounds of public protection.

91. However, the Committee considers that a finding of impairment is required to maintain public confidence in the profession and to declare and uphold proper professional standards of

conduct and behaviour. It is satisfied that a finding of impairment is necessary to mark the seriousness of your conduct towards your regulatory body.

92. The Committee considers that your dishonest omission breached a fundamental tenet of the profession, honesty and integrity, and has brought the reputation of the profession into disrepute. Therefore, limbs b, c and d of the test set out in CHRE v NMC and Paula Grant [2011] EWHC 927 (Admin) were engaged. In the Committee's judgement the public's trust and confidence in the profession, and in the regulatory process, would be significantly undermined if a finding of impairment was not made. The Committee therefore finds that your fitness to practise is currently impaired by reason of your misconduct in relation to the wider public interest.

Sanction

93. The Committee then determined what sanction, if any, is appropriate in light of the findings of facts, misconduct and impairment that it has made. The Committee recognises that the purpose of a sanction is not to be punitive, although it may have such an effect, but is instead imposed to protect patients and safeguard the wider public interests mentioned above.

94. In reaching its decision the Committee has again taken into account the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020). The Committee has applied the principle of proportionality, balancing the public interest with your own interests. The Committee has once more exercised its own independent judgement.

95. The Committee has paid careful regard to the mitigating and aggravating factors present in this case.

96. In respect of the mitigating factors that are present include:

- Previous good character;
- Single incident of dishonesty;
- Out of character;
- You have expressed remorse for and insight into your misconduct;
- Evidence of steps taken to avoid repetition;
- Time elapsed since the incident (4 years);
- No evidence of repetition.

97. In terms of aggravating factors, the Committee notes that you breached the trust that the GDC placed in you. The Committee did not consider your prior denial of dishonesty to being an aggravating feature.

98. The Committee has considered the range of sanctions available to it, starting with the least restrictive. In the light of its findings, the Committee considers that taking no action, or issuing a reprimand, would not be sufficient in the particular circumstances of this case. In the Committee's judgement public trust and confidence in the profession and in the regulatory process would be significantly undermined, if no action were taken or if a reprimand were issued. The Committee noted paragraph 6.9 of the guidance in relation to reprimand, and that many of the factors listed are present in this case, however, your dishonest conduct was deliberate and therefore a sanction of reprimand would not be sufficient to mark the seriousness of the misconduct found.

99. The Committee next considered whether it would be appropriate to conclude the case with a direction of conditional registration. The Committee found that it was unable to identify conditions which would be workable given the nature of the misconduct and the context of this case. The Committee finds that a direction of conditional registration would not be sufficient to declare and uphold proper professional standards of conduct and behaviour, and to maintain public trust and confidence in the profession, in the particular circumstances of this case.

100. The Committee next considered whether to direct a period of suspended registration. The Committee noted that paragraph 6.28 of the guidance indicates that suspension may be appropriate where public confidence in the profession would be insufficiently protected by a lesser sanction. After careful consideration, the Committee has determined that it would be appropriate and proportionate to suspend your registration. The Committee notes that your misconduct was serious and it finds that any lesser sanction would not sufficiently mark the gravity of the misconduct.

101. The Committee did consider whether the higher, and ultimate, sanction of erasure would be appropriate. However, it considered that erasure is not the only means of maintaining confidence in the profession in this case. Given the evidence of remorse, insight and remediation, the Committee was satisfied that this single incident of dishonesty did not represent a deep seated personality or a professional attitudinal problem. Therefore, the Committee determined that erasure would be disproportionate.

102. The Committee has determined that the appropriate and proportionate period of suspended registration is one of 3 months. The Committee considers that this period of time is commensurate with its findings, is sufficient to address the public interest considerations that it has identified.

103. The Committee determined that a review was not required a the end of the 3 months suspension, given its findings in relation to remorse, insight and remediation.

104. Whilst the Committee is mindful of the impact that this decision may have on you, it considers that its overarching duty to protect the public and the wider public interest outweighs your own interests in this matter.

105. The Committee now invites submissions as to whether your registration should be made subject to an immediate order of suspension, pending the substantive direction of suspension coming into effect.

Determination on immediate order – 19 March 2026

106. Ms Vanstone confirmed that there was no application by the GDC for an immediate suspension order.

107. You stated that an immediate order is not necessary and would be inconsistent with the approach of the GDC's revocation of the interim order on your registration this year.

108. The Committee accepted the advice of the Legal Adviser concerning its powers and the principles to which it should have regard. The Committee has again had regard to the GDC's *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, updated December 2020).

109. The Committee was satisfied that it was not necessary to impose an immediate suspension order on any of the statutory grounds.

110. That concludes this case.